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Supreme Court, U.S.
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Case No. _____

IN THE

UNITED STATES SUPREME COURT

Timothy B. Whitmore,

Petitioner Pro Se,

v.

Pierce County Department of Community Corrections, et. al.,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit:

PETITION FOR A WRIT OF CERTIORARI

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§ i. The Questions Presented:

1. Shouldn't a jail psychiatrist be presumed to have deliberate indifference when he fails to provide care according to known, legal and lawful, existing standards of practice, and inmates end up suffering as a result? Shouldn't knowledge of those standards of practice be presumed to exist if any one of the following conditions exist. In my complaint, I provided proof to show that each and every one of the following conditions existed:
   1.1. The care failed to meet the standards of practice that the psychiatrist was tested on in order to become licensed;
   1.2. The care failed to meet state laws regarding the requirement for all facilities within the state to provide qualified universal mental health assessment at intake, and to provide needed medication as soon as clinically possible thereafter; *RCW 71.05.050*[1]
   1.3. The care failed to meet the guidelines given to the jail by the lower court's compliance monitor; See *Appeal Dkts. 41* and *51.*
   1.4. The care failed to meet the standards of practice[2] in effect at mental hospitals and

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[1] Also see *RCW 18.130.180 (1), (4) and (7) and RCW 18.130.185.*

[2] At the time of my appeal, the only documentation I had the presence of mind to request from the State Mental Health Department was a series of procedural forms from Western State Hospital that outlined the hospital's obligation to provide a full mental health assessment by a psychiatrist or medical doctor at admissions, and to provide all medically necessary

correctional facilities, as regulated by the state;[3] See *Appeal Dkts. 16, 36* and *37.* Also see *Appendix § 2.2 pp. 43-48.*

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medication as soon as clinically possible thereafter. As a pro se plaintiff, my impression was that the standards of care governing those necessary and obligatory mental health treatment procedures could be inferred easily enough from those documents. Apparently I was wrong. In order to correct that problem, I am enclosing the Washington State Mental Health Department's *Interdisciplinary Treatment Guidelines* that govern those procedures in the *Appendix* to this petition.

[3] In past rulings, the Supreme Court has not made a distinction between mental health patients that are involuntarily committed or those that are incarcerated. *Title II of the ADA, 42 U.S.C. §§ 12131 34; Tony Goodman and the United States, et. al. v. Georgia, et. al., 546 U.S.151 (2006).* The argument here is an *Equal Protection Clause, Title II to the ADA* and *Tony Goodman ex rel United States v. Georgia* argument. In *Goodman and the United States v. Georgia,* the Supreme Court held that *Title II* to the ADA of 1990 applies to prisoners in state custody. In an eight-page opinion, Justice Antonin Scalia ruled that Congress has the authority to apply the *Americans with Disabilities Act (ADA)* to state prisons, at least insofar as it reaches conduct that could also be challenged under the Fourteenth Amendment. *Title II of the ADA, 42 U.S.C. §§ 12131-34,* prohibits discrimination by state and local government agencies. *Title II* covers all public agencies, whether or not they receive federal financial assistance ... *Title II* employs broad language in outlawing discrimination, stating that "*no qualified individual with a disability shall, by reason of such disability, be ... denied the benefits of the services, programs or activities of a public entity ...*" The Supreme Court has confirmed, in *PA Dept. of Corrections v. Teskey, 524 U.S. 206 (1998),* that this language covers all public entities '*without any exception.*'" - Bazelon Mental Health Law Clinic. See *Appeal Dkt. 78 p. 133 n. 94.* The Supreme Court did not make a distinction between civilly committed mental patients and

1.5. The jail employed only one part-time psychiatrist, and simple mathematics shows that this staffing level was not sufficient for meeting even the most routine of preventative mental health care needs for the inmates in an inmate population of 1,400. See ***Appeal Dkt. 67.***

2. Shouldn't a jail, and its part-time psychiatrist, be presumed to have deliberate indifference when he fails to provide care, or to supervise care, according to known, legal and lawful, existing standards of practice, and he fails to write a letter of protest to the head of the jail and the head of the county government about it?

3. Shouldn't the medical professionals in a jail medical clinic be presumed to have deliberate indifference when they were given ample notice that I had a serious bipolar disorder that required medication, as shown below, and they acknowledged the fact that I had this disorder?

4. Alternatively, how can the county government claim a lack of knowledge on what the constitutionally mandated necessary standards of practice are for preventative mental health care when they sue the state over their failure to

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convicted mental patients in *Donaldson v. O'Connor*, either. *Donaldson v. O'Connor, 493 F.2d 507 (5th Cir. 1974), vacated and remanded. O'Connor v. Donaldson 422 U.S. 563 (1975); See Mills v. Rogers, 457 U.S. 291 (1982).*

maintain those same standards of practice at a local state mental hospital and win? This is barred by collateral estoppel. See *Appeal Dkt. 59*.

§ ii. Parties to the Proceeding

Based on *Appeal Court Order Dkt. 8*, the petitioner and respondents for this case are as follows: Tim Whitmore, Petitioner; and, Pierce County Dept. of Community Corrections, Pierce County Dept. of Corrections Medical Clinic, Dr. Vasant Halarnakar, Pierce County Superior Court and Pierce County, Respondents.[4]

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[4] Please see ***Supp. Brief § 1 pp. 1-3*** on the *"Specific Facts Related to the Parties to the Proceeding"* for a discussion on the context in which the Appeals Court refused to dismiss the Pierce County Superior Court as a defendant.

§ iii. TABLE OF CONTENTS

Page

§ i. QUESTIONS PRESENTED ..... i-iv

§ ii. PARTIES TO THE PROCEEDING iv

§ iii. TABLE OF CONTENTS ..... v-viii

§ iv. TABLE OF AUTHORITIES ..... ix-x

1. PETITION FOR A WRIT OF CERTIORARI 1

2. OPINIONS BELOW 1

3. BASIS FOR JURISDICTION 2

4. APPLICABLE CONSTITUTIONAL PROVISIONS, STATUTES, ORDINANCES AND REGULATIONS 2-4

5. STATEMENT OF FACT 4-14

6. ARGUMENT – REASONS FOR GRANTING THE WRIT: 14-38

7. CONCLUSION 38

8. SIGNATURE DECLARATIONS 39

TABLE OF CONTENTS - APPENDIX

§ 1. The Lower Courts' Relevant Opinions and Judgments:

§ 1.1. The District Court's Report and Recommendation, Dkt. 223-1, dated 19 June 2007. 1-26

§ 1.2. The District Court's Order Adopting the Report and Recommendation, *Dkt. 236*, dated 19 July 2007. 27-28

§ 1.3. The District Court's Order Adopting Report and Recommendation, Dkt. 252, dated 20 Aug. 2007 29-30

§ 1.4. The Court of Appeals' Order, *Dkt. 45*, dated12 March 2008 *"referring petitioner's supplemental excerpts of record to the merit's panel that will hear the merits of this appeal for whatever consideration the panel deems appropriate"*; and, further ordering defendants to recognize that *"no motions for reconsideration, modification or clarification of this order ... be filed or entertained."* 31-33

§ 1.5. The Court of Appeals' Memorandum Affirming the Lower Court's Summary Judgment with an Unpublished Memorandum, *Dkt. 87*, dated 27 April 2009. This Memorandum was issued by Circuit Judges Susan P. Graber, Ronald M.

Gould and Carlos T. Bea. However, the original judges assigned to the case did not include any of these three judges. The original judges assigned to the case included Judges Thomas G. Nelson and A. Wallace Tashima. See *Dkt. 45* dated 12 March 2008. What's even more interesting is that Judge Tashima was one of the judges that issued the favorable ruling in the nearly identical case, Jett v. Penner, (9th Cir. 2006). 34-37

§ 1.6. The Court of Appeals' Order Denying the Petition for a Rehearing *En Banc, Dkt. 96*, dated 5 June 2009. 38-39

§ 2. State Regulations Governing Facilities that Are Obligated to Provide Mental Health Care 40-108

§ 3. Citations from Special Authorities

§ 3.1. Citations from Mental Health Experts at NIMH 109-118

§ 3.2. Citations from the Statisticians at the Dept. of Justice 119-124

§ 3.3. Citations from the Neuroscientists on Retainer at the Dept. of Justice. (The study from 2006 that was reprinted in this section has been

replaced by a newer study from Jan. 2009, which is more conclusive and 47% shorter .)

§ 3.4. Citations from the Dept. of Justice Civil Rights Division 125-140

§ 3.5. Citations from the U.S. Senate 141-144

§ 4. List Of The Supplemental Excerpts of Record by Docket Number 145-148

§ iv. Table of Authorities

CASES PAGE

Cf. DeShaney v. Winnebago County Dept. of Social Services, 489 U.S. 189, 198-199 (1989) ..... 14 n. 8

Craig v. Boren, 429 U.S. 190, 197 (1976) .... 25 n. 12

Donaldson v. O'Connor, 422 U.S. 563 (1975) ... iii n. 3

Donaldson v. O'Connor, 493 F.2d 507 (5th Cir. 1974), vacated and remanded ..... iii n. 3

Estelle v. Gamble, 429 U.S. 97, 103 (quoting in Re: *Kemmler*, 136 U.S. at 447) (1976) 25

Estelle v. Gamble, 429 U.S. 97, 97 S. Ct. 285 (1976) 25

Estelle v. Gamble, 429 U.S., at 103-104 25

Estelle, supra, 429 U.S. at 102. p. 10-11. Id. at 104 (quoting *Gregg v. Georgia*), 428 U.S. 153, 173 (1976) 25

Jett v. Penner, 439 F.3d 1091, 1096 (9th Cir. 2006) ..... viii, 3, 19, 23 n. 11, 24-25, 30-33

Massachusetts Board of Retirement v. Murgia, 427 U.S. 307, 312 (1976) .... 25 n. 12

Mills v. Rogers, 457 U.S. 291 (1982) ..... iii n. 3

PA Dept. of Corrections v. Teskey, 524 U.S. 206 (1998) ..... ii n. 3

Pierce County v. State of Washington, 144 Wash. App. 783, 185 P.3d 594; Thurston County Superior Court Case No. 03-2-00918-8, (10 Feb. 2006). ..... 15 n. 9

Sandra Herrera, et. al. v. Pierce County, et. al., 2007 WL 858341 (W.D. Wash.) ..... 10 n. 8, 13, 14, 20, 24, 25, 35, 36

Tony Goodman ex. Rel. United States, et. al. v. Georgia, et. al., (Case No. 04-1203 & 04-1236) 546 U.S. 151 (2006) 120 Fed. Appx. 785, reversed and remanded ..... ii n. 3

Yick Wo v. Hopkins, 118 U.S. 356 (1886) ..... 24 n. 11

§ 1. PETITION FOR A WRIT OF CERTIORARI

Timothy B. Whitmore respectfully petitions for a writ of certiorari to the United States Court of Appeals for the Ninth Circuit in the above-entitled case.

§ 2. OPINIONS BELOW

The unpublished memorandum from the U.S. Ninth Circuit Court of Appeals affirming the lower court's decision is reported at 2009 WL 1112759 (C.A.9 (Wash.) and is dated 4/27/2009. The Order Adopting Report and Recommendation by the U.S. Federal District Court, Western Washington - Tacoma Division, that contains the decision on my complaint that I'm appealing and petitioning for a Writ of Certiorari, is reported at 2007 WL 2116402 (W.D.Wash.) and is dated 7/19/2007.[5]

The other district court citations to this case are: 2007 WL 2409848 (W.D.Wash.), 2007 WL 1545252 (W.D.Wash.), 2007 WL 1246408 (W.D.Wash.), 2007 WL 601232 (W.D.Wash.), 2007 WL 419362 (W.D.Wash.) and 2006 WL 3300400 (W.D.Wash.).

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[5] This Westlaw citation repeats the incorrect reporting of a material fact. My rebuttal is found in *Supp. Brief § 2 pp. 3-6.*

§ 3. BASIS FOR JURISDICTION

I filed a petition for a rehearing *en banc* to the 9th Circuit Court of Appeals on 05/08/2009. (*Dkt. 88*). After (18) months of accepting my supplemental excerpts of record, (S.E.R.s 1-15), for review by the merits panel *"for whatever consideration the panel deems appropriate,"* my petition for a rehearing was found to be timely but was denied without comment on 06/05/2009. Consequently, the U.S. Supreme Court has concurrent jurisdiction with the 9th Circuit Court of Appeals over the subject matter of this complaint on appeal under *U.S. Const. Article III, § 2.* As just one basis for subject matter jurisdiction, I should also point out that the unpublished decision on my claim runs contrary to the 9th Circuit Court's ruling in *Jett v. Penner, 439 F.3d 1091, 1096 (9th Cir. 2006)*.

§ 4. Constitutional Provisions, Statutes, Regulations and Guiding Case Law

1. The 8th, 9th, 10th and 14th Amendments to the U.S. Constitution

2. 42 USC § 1983

3. 42 USC § 10805

4. Title II of the Americans with Disabilities Act, 42 U.S.C. §§ 12131-34

5. Tony Goodman ex Rel. United States, et. al. v. Georgia, et. al., 546 U.S. 151 (2006).

6. Jett v. Penner, 439 F.3d 1091, 1096 (9th Cir. 2006)

7. Revised Code of Washington (RCW), Title 71, Generally

8. RCW 71.05, Mental Illness

9. RCW 10.77, Criminally Insane – Procedures

10. RCW 72.23, Public and Private Facilities for Mentally Ill

11. Washington Annotated Code (WAC) 388-865, Generally

12. WAC 388-865, Community Mental Health and Involuntary Treatment Programs

13. Washington State Dept. of Health, Mental Health Division - Regulation Codified as Procedure 1.37: Inpatient Mental Facility Admission and Medical Stability Criteria

14. Washington State Dept. of Health, Mental Health Division, Interdisciplinary Treatment Manual - Assessments (Psychiatric Evaluation Guidelines)

15. Washington State Dept. of Health, Mental Health Division, Interdisciplinary Treatment Manual Guidelines for the Treatment Plan.

16. Washington State Dept. of Health, Mental Health Division, Medication Procedure Manual 801

§ 5.1. Statement of Fact:

Synopsis: I am a bipolar and I take anti-psychotic medication to treat my condition. With medication, my condition is generally quite manageable. I was taken into custody on a misdemeanor probation violation on 1 Nov. 2004. No provision was made at booking for me to receive my medication although the booking sergeant made a record that I had reported to her that I had this condition and that I needed medication to treat it. The following night I had a psychotic break which the guards reported. They also reported that I needed to see a doctor and mental health services. The following morning I was taken into the clinic and seen by a physicians assistant. Before the morning of 3 Nov. 2004 was out, my VA doctor at American Lake Veterans Hospital had sent a fax showing that as of my last visit with him on 10/21/2004 all of my medications were active. Those medications consisted of levothyroxine, bupropion, lithium and quetiapine. Only lithium and quetiapine are used to treat my bipolar disorder. The physicians assistant treated me for all my lesser ailments but she did not prescribe my lithium or my quetiapine for treating

my bipolar disorder. Under Washington State law she did not have the authority to make these prescriptions. The only one who did was the part-time jail psychiatrist. The jail only had one part-time psychiatrist for an inmate population of roughly 1,400 inmates. The physicians assistant, and other members of the Pierce County Jail medical clinic staff, knew I had a bipolar disorder and that it needed to be treated with medication. They knew this as early as my first night. They also made notes in my medical record that substantiate these facts. Nevertheless, I was not seen by the jail psychiatrist, and jail authorities did not issue a prescription for my lithium, until 22 Nov. 2004. I never did get a prescription for quetiapine. During this (22) day period when I was forced to go without my anti-psychotic medication, my condition was also exacerbated by being put on bupropion. This ran contrary to U.S. FDA warnings that were out at the time. During this (22) day period,[6] I suffered from

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[6] Because I only take my lithium and quetiapine at night, Nov. 1st was the first day I was forced to go without any of my anti-psychotic medication. I didn't see the part-time jail psychiatrist until the evening of Nov. 22nd. By that time the daily medication call to the pharmacy had already gone out, and so my medication was not available that night either. My lithium was not available until the evening of Nov. 23rd. I was not told at medication call that my lithium was in and available the night of Nov. 23rd, and so I didn't report to medication call until the following night when my existing bout of depression was not quite so severe. Therefore, it was not until the night of Nov. 24th that I finally received my first dose of lithium while in jail. I also had trouble getting my lithium prescription renewed when it ran out on 26 Feb. 2005, and for the same reasons. The

innumerable anxieties, panic attacks, and violent mood swings that were heightened by having to go without my medication. I also lost the ability to write a coherent medical complaint or grievance. Although the records of some of my other lesser medical complaints survived, none of my medical complaints about not getting my lithium and quetiapine my first month in jail were preserved by the jail. The jail's compliance monitor has noted that the jail's ability and resolve to protect and process written mental health complaints is a known and documented problem at that jail. I remained at the jail for (183) days. After I left the jail, psychiatrists for the U.S. Dept. of Veterans Affairs examined me and determined that my underlying mental health condition was worse than it had been before my jail experience.

§ 5.2 Facts

1. I was taken into custody on a misdemeanor probation violation on 1 Nov. 2004.[7]

2. Within (2) days the U.S. Dept. of Veterans Affairs provided two sets of records to the jail that from my VA medical record that showed I

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part-time jail psychiatrist was simply too busy to make the entries necessary to keep everybody's prescriptions current.

[7] For the list of references for Section § 5.2 on Facts see *Supp. Brief § 2 pp. 6-7.*

have a bipolar disorder, and that I have a serious need for medication to treat it.

3. Records were provided by both my VA doctor and the regional VA pharmacy.

4. The records my VA doctor provided were the most current. They were signed by my VA doctor on 10/25/2004, and were based on my last routine evaluation conducted on 10/21/2004.[8]

5. My VA doctor's records showed that all of my medications on my prescription list were active.

6. Within (2) days of being taken into custody, a jail physicians assistant and the jail psychologist both noted in my medical record that I had a bipolar disorder and that I needed medication for it.

7. The jail physicians assistant and the jail psychologist both noted that I needed to see the jail's part-time psychiatrist.

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[8] It should be obvious that the printed date the regional VA Pharmacy runs a print job from their database bears no relationship to when that computer data was last updated from the VA doctors' computerized *Patient Progress Notes*. This is inherent in the nature of databases that periodically replicate data obtained from other sources. However, from their *Statement of Facts*, this was not obvious to the district court.

8. No actual appointment for me to see the jail psychiatrist was made until 22 Nov. 2004, and I did not see the jail's part-time psychiatrist until 22 Nov. 2004.

9. Under Washington State law neither physicians assistants nor psychologists are authorized to prescribe psychotropic medication.

10. The jail's policies and procedures require that the inmate see the jail psychiatrist before any psychotropic medication is prescribed.

11. The standard of care promulgated by the State Mental Health Division and the National Commission on Correctional Health Care (NCCHC) is to provide medication 'as *soon as clinically possible'* upon admission regardless of whether the patient's previous prescriptions are current or not. This requires that, at a minimum, a psychiatric examination be performed by a qualified psychiatrist or medical doctor at admissions so that original prescriptions can be made. In other words, the standard of care is to get the mental health patient back on their medication as soon as clinically possible. This standard of care is not met at the Pierce County Jail.[9]

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[9] Specifically, under *RCW 71 et. seq.*, correctional facilities containing inmates with mental health disorders are to be governed by the same regulations that that apply to mental health facilities that treat involuntarily committed patients. These regulations are codified by the State Mental Health

12. The NCCHC and the State Mental Health Division have another standard of care that requires that mental health assessments be performed universally for all inmates and/or mental health patients at admission by a qualified psychiatrist or medical doctor.

Department. The state's regulations that prohibit the intentional and purposeful delay of vital psychotropic medication are as follows:

1. The [State's] Admitting Criteria Procedure 1.37
2. The Interdisciplinary Treatment Manual for the psychiatric evaluation clinical profile.
3. The Interdisciplinary Treatment Manual for the treatment plan.
4. The Interdisciplinary Treatment Medication Procedure 801 which describes the ordering of medications
5. The Interdisciplinary Medication Procedure 801 which describes the definitions of administering medications.

Specifically, the jail failed to comply with the following regulations governing mental health examinations at admissions, and with regards to the prescription and administration of medication at admissions and thereafter: *State Admitting Criteria [AC] § 1.37 IV.A.4, [AC] § 1.37 IV.E.3.(e-f), Interdisciplinary Treatment (IDT) Manual for Psychiatric Evaluations ¶ 2, ¶ 2.1.(c-d), ¶ 2.3, ¶ 2.4.a, ¶ 2.6.1, ¶ 2.6.3.(h, k, m-n), ¶ 2.6.4.g.9, ¶ 2.6.4.gh.20, ¶ 2.6.5.a.(1-2), ¶ 2.6.6.m, ¶ 2.6.6.n.2, IDT Medication Procedure 801 § Safety Procedures ¶ 1, ¶ 4, § General Information ¶ 1.G, ¶ 1.H, ¶ 1.K.5.b, ¶ 1.N.(1-2), ¶ 4, and ¶ 5.* See the ***Appendix*** for the full text of these regulations. Additionally, the *Herrera* compliance monitor repeatedly warned the jail to correct the correct the problems it has with its mental health intake and medication administration procedures.

13. The jail had only one part-time psychiatrist for providing psychiatric care to an inmate population of roughly 1,350. This level of staffing for psychiatrists is not sufficient, and can be readily recognized as being so.

14. Washington State Law requires that a person who has been involuntarily detained receive a full mental health examination by a qualified psychiatrist within (6) hours of being delivered to the facility.

15. I did not see the part-time jail psychiatrist until 22 Nov. 2004.

16. My jail medical record shows that my VA doctor called the jail clinic at least three times admonishing them to put me back on my lithium before I finally saw the jail psychiatrist.

17. Lithium is a medication that requires constant blood level monitoring in order for it to be safely administered.

18. I was jailed for a total of (183) days. During that time, the jail only performed one lithium blood level test.

19. The jail never did provide me quetiapine, the second psychotropic drug that is part of my medication regimen.

20. Levothyroxine is not a psychotropic medication and is not used to treat bipolar disorders.

21. TSH+Reflex and Free T4 blood tests are used to monitor thyroid conditions, <u>not</u> bipolar conditions.

22. Contracting a thyroid condition is frequently a side effect from using lithium, which is the primary medication used for treating bipolar disorders. Therefore, having to treat a thyroid condition is another indication that treating an underlying bipolar condition is needed.

23. Levothyroxine is a 'general practice' medication that physicians assistants in the State of Washington are permitted to prescribe. Lithium and quetiapine are not. Only psychiatrists and medical doctors are allowed to prescribe lithium and quetiapine in the State of Washington.

24. Medical experts have shown that improperly taking a patient with the bipolar disorder off lithium increases their risk of suicide, and other harmful and destructive behaviors, by a factor that is in excess of (5) to (1).

25. After I left jail, psychiatrists working for the U.S. Dept. of Veterans Affairs determined that my mental health condition had become significantly worse than it had been before I had gone to jail.

26. From the notice given by the court-appointed compliance monitor in *Herrera*, the jail has had (13) years to correct its deficiencies in failing to implement the following:

26.1. Universal mental health assessment by a licensed psychiatrist or medical doctor upon detention, to be generally conducted within (6) hours of detention.

26.2. Periodic mental health check-ups by a licensed psychiatrist or medical doctor for all inmates who need it, including those in segregation, on a nominal (2) week interval.

26.3. Psychotropic medication to be provided as soon as clinically possible upon detention, and generally within (6) hours of detention.

26.4. Proper discharge treatment plans developed and made available for every inmate that needs one before the inmate's sentence is up without forcing the inmate to stay longer while the discharge treatment plan is prepared at the last minute.

26.5. Necessary and proper periodic blood tests for all inmates on medications that require blood monitoring taken on the periodic interval recommended by the pharmaceutical company that makes the medication.

27. I did not learn about the *Herrera* v. *Pierce County Jail* case, or its expected disposition, until after my district court action had concluded. In *Herrera*, the Pierce County Jail's mental health care violations cited in *¶¶ 26.(1-5)* above were found to be the result of deliberate indifference, and thus constitutional violations of the 8th Amendment, that were sufficient to motivate the Pierce County Jail to agree on paper to correct those problems, as identified and instructed, by the court-appointed compliance monitor. Even so, after all this time they have failed to do so. *Whitmore Appeal Dkts. 41 and 51.*

28. I did not learn that Pierce County had successfully sued the state, and a local state mental hospital, for failing to implement the same constitutionally mandated standards of mental health treatment and care that I had complained about until after my district court action had concluded. That makes Pierce County's current position in my lawsuit barred by the doctrine of collateral estoppel. *Whitmore Appeal Dkt. 59.*[10]

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[10] See *Supp. Brief § ii p. ii* for the Westlaw citation to this case.

§ 5.3. The Original Jurisdiction for Federal District Court

The appellees reported in their original reply brief to the appeals court that the district court had jurisdiction in the matter of my complaint pursuant to *28 USC § 1343(a)(3)*. This was a matter was never contested.

§ 6.1. The Argument:

If jail doctors aren't required to have the care they administer meet known and lawfully regulated standards of practice, then you can throw the *Equal Protection Clause* right out the window. Under those conditions, there will be no motivation to prevent negligence, while at the same time, the presumption of deliberate indifference will have been met.

Additionally, the standards of practice used to regulate mental health care in government facilities, i.e. facilities that are subject to the *14th Amendment* and/or *42 USC § 1983*, become voluntary rather than compulsory. If that were to happen, there would be no point in regulating the standards of practice governing mental health care in government facilities because having standards that are optional is meaningless.

When medical professionals fail to comply with known standards of care, this is not a failure due to a lack of knowledge. Their licenses to practice medicine create a presumption that they have a knowledge of the standards of care that they are to

apply and to use to govern themselves as professionals. Whether they choose to practice in accordance with those standards of care is another thing, and it is a matter of conscious choice. However, this choice might be made for them by the administrators of the jail facilities or county where they work, but they still have an obligation to put those administrators on notice with a letter of protest if the standards of care they are forced to use do not meet the recognized and regulated standards applied to their industry.

Likewise, the administrators that run the county government and its jail, have an obligation to listen to their doctors and their medically licensed medical directors to insure that their facilities are not being run on a sub-standard basis, which would put them at odds with the regulating authorities. Such a situation signals an *8th Amendment violation.* The failure to acknowledge state law, or to listen to their doctors' recommendations, or in the worst case, their failure to listen to a court-appointed compliance monitor's instructions, creates the presumption of knowledge on their part that's necessary for establishing deliberate indifference.

When licensed medical professionals, and their handlers, fail to comply with known standards of care, it is not due to a lack of knowledge about what those standards are. In the extreme case, ignorance of the law is not an excuse. Instead, the failure to comply is the result of constraints placed upon the jail's medical professionals by jail officials, county officials and/or county budgeteers. Once the jail has hired one or more duly licensed medical professionals

with the right qualifications, there must be a presumption that those medical professionals know what they need by way of staffing and resources in order to do the job right. If they don't ask for what they need, or if they don't ask for what they need to comply with existing standards, that's a deliberate failure in both responsibility and planning. If they ask for what they need and they don't get it, or a court compliance monitor states the obvious for them only to be rebuffed, then the policy-makers who have refused to provide the necessary staffing and resources have taken the decision on how to do the job right away from their medical professionals at their own peril. By doing so, they assume responsibility for the liability that accrues from their own bad decisions; and so those county officials cannot plead ignorance of what is necessary to do the job right because the state laws, state board regulations, approved industry practices and the court compliance monitor instructions are all adversely tolled are all documented for the public to see.

Thus, the nature of the knowledge applied here that demonstrates deliberate indifference is different from virtually all forms of deliberate indifference that the court has previously identified and defined. It falls outside the court's typical definition of deliberate indifference. Deliberate indifference usually assumes a knowledge of things as they were, as they are, or as they may very well be in the future. It takes into account one's professional judgment in having to guess or anticipate the likelihood of that which may not be known until after

it has happened, and by then of course it is too late to take preventative measures.

Taking preventative measures is the sign of the responsible mind. The Boy Scout Motto is and will always remain, "Be Prepared," but that high standard is not being used here because standards of practice are always spelled out as a set of recommended procedures to be followed to minimize policy and process errors, as opposed to minimizing errors in professional judgment.

In the medical world, the guesswork is in determining which treatments or medicines to use, and not which standards of practice to follow. There is no guesswork in determining which standards of practice to follow because the standards regulating authorities dictate what those standards are for you. These standards regulating authorities and accreditation boards have only one set of standards to follow at any given time, and generally these standards boards mirror each other. That is why they are called standards. For any given process, there is only one set of standards that can apply, otherwise you don't have standards. You have conflicting process flow instructions and divergent expectations instead; but that is not the case in modern medicine. Medical practices adopt one set of lawful and recognized standards to follow, and they stick to them until they are revised and improved. If they don't stick to them, then they are culpable for failing to follow appropriate standards; and there is no question about that because these standards are known to all concerned. Otherwise, they could not be called standards.

§ 6.2. The Precedent for the Argument:

"Deliberate indifference may appear 'when prison officials deny, delay, or intentionally interfere with medical treatment, or it may be shown by the way in which prison physicians provide medical care. Jett v. Penner, 439 F.3d 1091, 1096 (9th Cir. 2006)." From *Whitmore Appeal Dkt. 38, Summary p. 5.*[11]

My case cites as precedent the Jett v. Penner case wherein the 9th Circuit found that delays in treatment, that do not meet existing standards of practice, constitutes a material fact that establishes deliberate indifference. In my case, contradicted themselves with respect to their ruling in Jett v. Penner. The jail's (22) day delay in providing my medication was unconscionable. The material facts that caused that abhorrent delay in my treatment are as follows:

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[11] VERY IMPORTANT NOTE: In my appeal to the 9th Circuit Court, I typed this reference wrong. I referred to this case as Jett v. Palmer, 439 F.3d 1091, 1096 (9th Cir. 2006). However, the 9th Circuit should have recognized this case as the Jett v. Penner case because the numeric portion of the citation was correct. However, this reference was correctly reported in Whitmore Appeal Dkt. 38, Evidence p. 5. This is Acting Assistant Attorney General Rena J. Comisac's report on the King County Jail wherein the DOJ complained of the same deficient standards of practice for mental health care in effect at that jail that I have complained of and cited them as constitutionally actionable violations of the 8th Amendment.

1. The jail's failure to provide a mental health assessment by a qualified psychiatrist or psychiatric nurse practitioner at intake so that my lithium and quetiapine medications could be prescribed is a deliberate failure that meets these standards of practice:
   1.1. As regulated by the State Mental Health Department, Appeal Dkts. 16, 36 and 37.
   1.2. As instructed by the *Herrera* compliance monitor, but those instructions regarding mental health care were never followed. *Appeal Dkt. 51, Vol. I, Tab 9, p, 2; Tab 12; Tab 17 p. 5*
   "... It is the intent of the court, PCDCC, and myself, that more than the minimum of standards be met. It is the intention to bring health care at PCDCC to a ***reasonable*** *but high quality standard of care ... There has been an agreement between the Health Services ...at PCDCC and myself to use the standards as set ... by the National Commission on Correctional Health Care ..."*

   Dr. Steven Shelton repeated himself by reporting in Sept. 2005 that these standards require:
   1.2.1. A properly composed and sufficiently sized mental health staff – Goal C-07; *Tab 17 p. 13.* This was not met.
   1.2.2. Proper *"full"* mental health assessments *"completed for each inmate as soon as possible after*

arrival ..." - Goal E-04; *Tab 17 p. 15.* This was not met. A full mental health assessment includes prescribing all needed psychotropic medications without delay and not (22) days later.

1.2.3. Proper mental health screening and evaluation. Universal screening by a qualified psychiatrist at intake is required – Goal E-05; *Tab 17 p. 16.* This was not met.

1.3. As required by state law. ***RCW 71.05.050*** requires that involuntarily committed mental patients housed in either correctional facilities or mental hospitals receive a complete mental health examination by a qualified doctor or psychiatrist, with pharmaceutical writ authority, within (6) hours of delivery to the facility. A complete examination includes the prescription and administration of any and all needed psychotropic medication as soon as clinically possible thereafter.

1.4. In *E.R. I Dkt. 217 p. 2 ¶ 5*, the jail's Health Systems Manager, Vince Goldsmith, stated that delivery of medically needed medication will take place once one or more of the following things happen:

1.4.1. The inmate informs staff that he needs medication. I did this at my initial screening but to no avail because the jail psychiatrist was unable to see me until 22 Nov. 2004. *E.R. II Dkt. 188-2*

pp 1-2; E.R. III Dkt. 114 p. 4; D.C. Dkt. 186 pp. 7, 11. By then the deterioration to my mental disorder was done. *E.R. II Dkt. 179-1 pp. 11-72; E.R. II Dkt. 188-3 pp. 8-59.*

1.4.2. The inmate's family or the inmate's outside doctor informs staff that he needs medication. Both my family and my VA doctor did this repeatedly but to no avail because the jail psychiatrist was unable to see me until 22 Nov. 2004. *E.R. III Dkt. 114 pp. 4-6, 9-10; D.C. Dkt. 186 p. 8; E.R. I Dkts. 190, 224, 243; E.R. III Dkt. 114 pp. 4-6, 9-10;* By then the deterioration to my mental disorder was done. *Id.*

1.4.3. From the facts above, it should be clear that the jail medical clinic staff had been given ample notice that I have a serious bipolar disorder that requires constant medication. *Id.* Additionally, the jail guards reported that I had a mental health condition that needed immediate attention by the jail doctor or psychiatrist, but no such treatment was provided until 22 Nov. 2004.

1.5. During the (22) days when I was not getting any of my anti-psychotic medication, I tried to the best of my ability to inform jail staff of my need for anti-psychotic medication to prevent my mental disorder from becoming worse permanently by both written 'kite' and written grievance but those written communications

were lost by jail staff or were not acted upon. However, sufficient material evidence of deliberate indifference in failing to act on the ample notice shown above in *¶1-¶4* has already been provided. Even so, I am still entitled to also infer that these additional written kites and grievances were received by the appropriate jail authorities.[12]

1.5.1. This entitlement is established by the facts presented in *E.R. III Dkt. 176* wherein I am able to demonstrate that most of my kites and grievances, that I submitted to my cellblock's jailkeepers, which were the only jail authorities I had actual access to, were lost or left unprocessed.

1.5.2. This entitlement is also established by the written testimony presented by the *Herrera* court compliance monitor:

"It does not appear that a psychiatrist sees or reviews the medication while the inmates are in jail. No policy was located describing this practice." Appeal Dkt. 51, Vol. I, Tab. 28 p. 11.

"We also identified problems with the access to mental health care. Patient-inmates with mental health concerns submit kites which are then picked up ... and referred to mental health

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[12] **Jett v. Penner, 9th Circuit Court Case No. 04-15882, 9 March 2006, Opinion, p. 2400**

> *services ... This review does not always take place in a timely manner. Patient-inmates who were interviewed complained about the long delays and the need for multiple kites in order to be seen. Unlike medical kites, there is no policy that requires a response to the mental health kite. Appeal Dkt. 73, Vol. III, Tab 2 p. 5.*
>
> *The mental health services at PCDCC continues to operate with only 14 hours of psychiatrist time per week ... The current coverage is not adequate to serve the mental health needs of the PCDCC population. Long delays, [on the order of] 30 days, were found during chart review and some patients were never seen, even though there were multiple referrals to the psychiatrist ... Id. p. 10.*

With its unpublished decision to affirm the lower court's critically unexamined summary judgment, especially in light of the unresolved *Herrera* case's boondoggle legacy, the appeals court rendered a decision in my case that contradicts their published views in Jett v. Penner on the constitutional impropriety of denying or delaying medical treatment in jail. They did not rule on the applicable points of law either.

At no time did the district court or the appeals court address the *Equal Protection Clause*[13] aspect of my complaint, either, which runs parallel to the *Estelle v. Gamble* aspect of my complaint.

§ 6.3. A Comparison of My Case to the Precedent, *Jett v. Penner* Case:

In the Jett v. Penner case, an inmate named Lance Jett fell out of his bunk on a weekend and fractured his thumb. He was seen by Dr. Johnson, an emergency room doctor at Mercy Hospital in Folsom California, who diagnosed his fracture that same day. Dr. Johnson wrote an aftercare instruction for Lance Jett to be seen by an orthopedic doctor right away, early the following week. Lance Jett was also prescribed pain medication, and this medication was provided by the jail doctors. Lance Jett never saw an orthopedic doctor the following week. He went without seeing a doctor for almost (2)

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[13] *Yick Wo v. Hopkins, 118 U.S. 356 (1886) (State may not deny services to certain disfavored groups without violating Equal Protection Clause. Governmental inaction is actionable under the Equal Protection Clause).* Incarceration status and *"fundamental [8th Amendment] rights"* require *"strict scrutiny." Massachusetts Board of Retirement v. Murgia, 427 U.S. 307, 312 (1976). "Equal protection analysis requires strict scrutiny [for those categorized as wards of the state]."* This is especially important because the state of being incarcerated *"operates to the peculiar disadvantage of that ... class." Craig v. Boren, 429 U.S. 190, 197 (1976). Palmer & Palmer, Loc. Cit. pg. 65n36; 72*

months until 24 Dec. 2001. Subsequent to that date, jail x-rays showed that his fracture had healed improperly with a slight deformity, which the jail doctor, Dr. Penner, chose to overlook. It was not until 29 April 2002 that an orthopedic specialist from Manteca California examined Lance Jett's hand and diagnosed his hand as improperly healed. As of 30 May 2003, the fracture in Lance Jett's hand had still not been corrected; but corrective surgery, which was to include a pin placement to correct the deformity, was anticipated.

In the Jett v. Penner case, the record showed that the jail doctor tried to cover up knowledge of the improper healing, but this evidence was nothing more than the fact that the doctor had crossed out a single word in his report. The change to the meaning of that part of the report can only be described as subjective. However, in my case jail clinic staff repeatedly wrote in my record that I needed to be seen by the jail psychiatrist so that my anti-psychotic medications could be prescribed, but at no time before my impromptu and unscheduled appointment on 22 Nov. 2004, was an appointment for me to see the jail's part-time psychiatrist ever made. That appointment only occurred after my VA doctor called a third time to act as an advocate on my behalf, as documented by the record. Additionally, no evidence is found in my record that any of the PCJ's licensed professionals ever bothered to schedule that appointment in advance of its occurrence.

The material facts show that deliberate indifference existed in both cases because treatment was delayed well beyond the point when it would

have been considered timely. Here are the quotes from my jail medical record that substantiate this assertion:

> *"Inmate should be see[n] [by the] doctor and possible visited [sic] by mental health professional [sic]."* - Correctional Officer William D. Laneer, 11/3/2004, 1:45am. *E.R. II Dkt. 188-1 p. 118.*
>
> *"Mental health professional staff please review."* - Correctional Officer Philip S. Sadler, 11/3/2004, 3:00am. *Id.* Please note that mental health professionals do not have psychotropic prescription authority.
>
> *"Inmate ... reports mental health diagnosis of schizoaffective disorder, bipolar disorder with rapid cycling and should be on seroquel ... [Diagnosis] 1. Schizoaffective disorder per history; 2. Bipolar disorder with rapid cycling per history. [Treatment Plan] ... [Request information from] psychiatrist VA Mental Health Clinic for current medication list."* Juliette Pohl-Y-Baca, Physicians Assistant, 11/3/2004, 10:12am. *E.R. II Dkt. 188-2 p. 1.* Please note that physicians assistants do not have psychotropic prescription authority.

My VA doctor sent the jail clinic a fax on 11/3/2004 at 11:43am that contained my most recent

Patient Progress Note from my last visit with him on 10/21/2004. This *Progress Note* contained a list of my medications. This list was comprised of bupropion, levothyroxine, lithium and quetiapine, and each and every one of those medications was listed as ACTIVE. *E.R. III Dkt. 114 p. 9.*

> *"Inmate ... revealed that he had been going to VA hospital for mental health reasons ...* ***He maintains that he isn't on all the medication that he normally gets and is feeling the effects.***[14] *He will be put up to be seen by the psychiatrist. ... An attempt [?] to connect with mental health [at American Lake] ... will be made in the future."* - Ann Elek, Clinical Psychologist, 11/3/2004 4:20pm. *E.R. II Dkt. 188-2 p. 2.*

Please note that as of 11:43am earlier that day, the jail clinic had all the confirmation they needed to know what my medications were and that they were all ACTIVE. Please also note how quickly my VA doctor sent that fax (11:43am) after Juliette

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[14] Under the cognizant state mental health regulations, it is the receiving facility's responsibility to provide whatever psychiatric exams are necessary to sort out a patient's prescription history to get him or her back on the medication they need as soon as possible. This is not some outside doctor's responsibility, and to suggest otherwise is to be inappropriately passing the buck. See ***Appendix § 2***.

Pohl-Y-Baca called him to get that information. (10:12am).

> Mental Health Screening Report: *"... Seen because he had been acting strangely, taking a shower after hours and his anxiety level was growing ... Appearance: Hair a little wild, he kept rubbing his hands through his hair. Psychomotor Activity – Agitated: Reported being antsy. Behavior/Manner -- Affect, Euphoric. Seemed just a bit too cheerful under the circumstances. Mood: Euphoric. This may be exaggerating but he was pretty cheerful."* Ann Elek, Clinical Psychologist. *E.R. II Dkt. 188-1 p. 119.*[15]

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[15] Ann Elek was a clinical psychologist with a master's degree. She should have recognized these symptoms as acute mania. Unwarranted euphoria is a strong indicator that mania is present. Specifically, the National Alliance on Mental Illness reports that:

"Symptoms of mania include: Increased physical and mental activity and energy, heightened mood, exaggerated optimism and self-confidence, excessive irritability and aggressive behavior, decreased need for sleep without experiencing fatigue, grandiose delusions, inflated sense of self-importance, racing speech and thought, irrational ideas, impulsiveness, poor judgment and distractibility, and reckless behavior, such as spending sprees, sexual indiscretions and/or alcohol abuse. E.R. II Dkt. 188-1 pp. 58, 59.

Typical symptoms of mania include pressure of speech, motor hyperactivity, reduced need for sleep, flight of ideas,

"Inmate will be releasing from jail December 7th or 10th and gets health care through VA American Lake." - Juliette Pohl-Y-Baca, Physicians Assistant, 11/15/2004, 1:29pm.

"Dr. Robert Williams from VA hospital called ... He said that [the] inmate's bipolar disorder is not under control and he wouldn't recommend welbutrin for him at this time. He recommends that he be put back on lithium and something else for sleep ... Inmate has an appointment at VA for Dec. 14th at 3:00pm with Dr. Williams. Inmate can get his medication at the VA, [yeah, once I'm out], there are standing orders in the [VA's] computer." - Ann Elek, Clinical Psychologist, 11/17/2004, 4:25pm. *E.R. II Dkt. 188-2 p. 2.* Please

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grandiosity, elation, poor judgment, aggressiveness, and possibly hostility." Id. p. 98.

In point of fact, Ann Elek's mental health screening report shows that she did recognize my symptoms as those of acute mania. Otherwise, she would not have emphasized the fact that I was "*a bit too cheerful under the circumstances.*" This written observation shows that she recognized that I was manifesting the symptoms of an out of control manic condition. She simply chose to use words that would look harmless. This is no different than what Dr. Penner did in the Jett v. Penner case wherein Dr. Penner crossed out the single word "*obvious*" in his report stating that Lance's x-rays "*showed no ~~obvious~~ fracture malalignment.*" Jett v. Penner, Opinion p. 2401.

note that if there were standing orders in the jail's computer, I would have been getting my medication the whole time I had been in jail, but I wasn't. Ann Elek was passing the buck to another government agency based on services that could only occur after I got out of jail.

"42 year old Caucasian male, a veteran with 100% disability reports having a diagnosis of schizoaffective disorder. He says he has been with VA since 1998. His psychiatrist Dr. Williams called to suggest that his welbutrin be discontinued and he be put on lithium. He has been getting more manic and aggressive may be because of welbutrin ... Appears younger than stated age. He is agitated but trying to cooperate. Affect-agitated, mood-high. Speech-rapid, pressured ... Mood disorder ... Report of bipolar disorder. Discontinue welbutrin. Start on lithium ..." Dr. Vasant Halarnakar, 11/22/2004, 6:43pm. *E.R. II Dkt. 188-2 pp. 2, 4.*

A condensed version of the 9th Circuit Court of Appeals' opinion in the Jett v. Penner case that reviewed similar facts is as follows:

Plaintiff Lance Jett, who fractured his right thumb while housed in California State Prison ... alleg[ed] Defendants (1) violated his constitutional rights by being

deliberately indifferent to his serious medical needs in violation of the Eighth Amendment and (2) violated California Government Code § 845.6 by failing to ensure he timely saw an orthopedist to set and cast his fracture as directed by the initial physician's aftercare instructions. ... We have jurisdiction over this timely appeal and hold the district court erred in adopting the magistrate's Findings and Recommendations because (1) Mr. Jett provided sufficient evidence, including medical slips, a letter, and a grievance, to demonstrate the existence of a genuine issue of material fact as to whether Dr. Penner's failure to see Mr. Jett prior to December 24, 2001, was deliberate indifference; (2) Mr. Jett provided sufficient evidence to demonstrate the existence of a triable issue of fact as to whether Dr. Penner's post-December 24, 2001, conduct was deliberately indifferent to Mr. Jett's need to have his fractured thumb set and placed in a permanent cast; (3) Mr. Jett presented sufficient evidence to establish the existence of a genuine issue of material fact as to whether Dr. Peterson and Warden Pliler were deliberately indifferent to Mr. Jett's condition because Mr. Jett is entitled to an inference that these individuals received the letters Mr. Jett wrote and sent via institutional mail advising of his fractured

> *thumb and need to see an orthopedist; and (4) Mr. Jett stated a cause of action under California Government Code § 845.6 because this statute requires medical care to be summoned for an inmate who needs immediate medical care to have a fractured bone set and cast ...* **Jett v. Penner, 9th Circuit Court Case No. 04-15882, 9 March 2006, Opinion, pp. 2399-2400**.

The material facts show that Lance Jett's injury was not a life-threatening one. Lance Jett fractured his thumb. Mine injury was a mental one. The delay in the treatment of bipolar disorders with the administration of lithium has been shown by medical experts from the National Institute of Mental Health to be a life-threatening condition. Without medication, the chances that someone with a bipolar disorder will become suicidal or a threat to themselves or others is 5 to 10 times greater than when they are receiving lithium, or some other suitable anti-psychotic medication. Lance's thumb was allowed to heal crooked by the jail doctor; but this was only a temporary problem. It certainly was not a life-threatening one and he was provided medication for the pain. Eventually outside doctors diagnosed the deformity in Lance's thumb from the improperly healed fracture and reset his thumb with pins to correct the deformity. In other words, Lance's injury was not permanent one, whereas the deterioration of my mental health from being forced to go involuntarily off my lithium and quetiapine medication the first (22) days I was in jail has been

shown to have been permanent by psychiatrists working for the U.S. Dept. of Veterans Affairs. Medical experts have also shown that withholding lithium from those who have the bipolar disorder increases their risk of harm to self or others by 5 to 10 times what it is when that person is properly medicated. Tolerating increased risks of harm like that runs contrary to the accepted standards of practice, and so it is tantamount to deliberate indifference.

Lance Jett was provided with pain medication from the start. In contrast, my bipolar disorder created mental stress, irrational anxieties, phobias and violent mood swings during the period when I was forced to go unmedicated. This emotional trauma was painful and unpleasant, and it could have been alleviated simply by providing me with the anti-psychotic medication I was denied in a timely fashion as soon as I was taken into custody. Previous to this, the record shows that I had been on the anti-psychotic medication that was part of my current treatment plan, but that fact is moot. It has no bearing on the ruling in my case.

Lance Jett was of sufficiently sound mind to file medical slips and a grievances to attract the jail officials' attention to the fact that he was not receiving proper and timely medical care. During the first (22) days I was in jail I lost the ability to write a coherent statement to complain about the denial of my lithium and quetiapine medication. Even so, the *Herrera* compliance monitor has pointed out that mental health kites and petitions at the Pierce County Jail are not reviewed in a timely

fashion and that frequently they are not reviewed at all. *§ 6.2.1.5.2.* Furthermore, I have documented the fact that many of my kites and grievances were lost or left unreviewed in *§ 6.2.1.5.1.* above. Lance Jett did not have this problem. Why should I be penalized because this problem exists at the (PCJ). Even so, I was able to provide ample notice to the jail medical clinic staff from my VA medical record and from the requests and subsequent complaints from both my family and my VA doctor. However, the clincher is the fact that both the jail guards and the jail clinic staff alike, all of whom were not licensed to prescribe psychotropic medication, stated in their written reports and medical record entries that I needed to see the jail psychiatrist.

In other words, in my case I even had jail guards documenting the fact that I needed to be seen by the jail's psychiatrist. These entries were made on 3 Nov. 2004. The guards did not do this for Lance Jett in his complaint. Finally, it appears that the jail medical staff was of a sufficient size at CSP-Sacramento to handle Lance Jett's medical needs if they had chosen to do so. (That is not the case at the Pierce County Jail, which is under-staffed and cannot meet its inmate population's psychiatric needs.) Like my situation where the information that was needed to act on was known, the doctors and medical staff at CSP-Sacramento were certainly capable of sending Lance Jett to see outside specialists long before they finally got around to it. What is the difference here between Lance's situation and mine, where I was forced to go without my medication for (22) days while still having to deal

with my bipolar disorder every minute of that time? Is (22) days not long enough for my suffering to be considered serious? With regards to providing proper mental health care, the PCJ is not in a similar position as CSP-Sacramento. It cannot choose whether or not to provide care internally or externally because the PCJ psychiatric staff is grossly understaffed and that limits their internal capabilities. This is something they have acknowledged in the *Herrera* case. They have admitted they are understaffed. The PCJ's one part-time psychiatrist, and its existing mental health worker staff, is not sufficient for performing the job of providing proper mental health assessments at intake and at the required periodic intervals thereafter. These required periodic mental health assessments, for inmates who have been diagnosed as having mental health problems, are supposed to occur every (2) weeks.

The composition of the jail medical clinic's staff does not support the ability to prescribe antipsychotic medication at intake, when needed or required. Physicians assistants, regular nurses, psychologists and state mental health professionals cannot prescribe psychotropic medication under Washington state law; and a single part-time psychiatrist on staff, that only works (14) hours a week, is not enough to meet the jail's routine and urgent psychiatric needs.

The study of pain and the measurement of the severity of pain is highly subjective, and does not lend itself to legal analysis. Lance Jett's claim is that he fell out of his bunk and fractured his

thumb.[16] Regardless of how he actually broke his thumb, the record shows that it was broken and needed to be mended.

However, evolving clinical practice shows that emotional pain and suffering is much more painful than physical bruises and factures.[17] The study of the bone fractures and other injuries sustained by gymnasts is a case in point. When I was a senior in high school, I suffered a hairline fracture to my right wrist during a post-season gymnastics practice.

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[16] I've been to sea more than just a few times as a Naval Surface Warfare Center radar systems engineer and shiprider, and I've slept in my share of unbelievably narrow overhead racks in all sorts of sea conditions. From those experiences I learned by observation that if you fall out of your overhead rack when you're asleep, your whole body is going to be relaxed when you hit the deck, and so you can expect to bend rather than break. Because your body will be relaxed when you're sleeping, it's not likely that you're going to break anything when you hit the deck. What I've observed is that when this happens to someone, they wake up very suddenly and very painfully. They are typically bruised in the soft tissue areas of their body where they've landed, including their skull, but as a person falls, their limbs and joints bend freely and lay naturally when they impact the deck.

[17] As just a quick example of this, I would like to point out that the U.S. Dept. of Veterans Affairs' take on emotional trauma can be summarized by their current ad campaign. This ad campaign reads as follows: *"It takes the courage and strength of a warrior to ask for help ... If you're in an emotional crisis call 1-800-273-TALK."* This proactive approach to handling emotional trauma did not exist in previous wars. This is just one indication of how society's standards have evolved in this area.

Even with that hairline fracture, I successfully completed that portion of Plebe Summer at the Naval Academy that I chose to complete without making any physical complaints. Over the course of my life, I have been actively engaged in many different sports. I have even built my own house. Since the time of the initial injury, that hairline fracture in my right wrist has opened up from time to time and has caused me pain, but I have never sought followup treatment for it. The difference there is that that was my choice. I was able to make that choice for myself. In contrast, I did not choose to forgo taking either lithium or quetiapine when I got to jail, and the denial of choice makes all the difference in the world.

I don't think you can create a legal standard to compare or rate one kind of pain against another. For me, emotional pain and suffering is much more severe and much more difficult to bear than physical pain.[18] As one who has the bipolar disorder, I am not equally equipped at handling emotional pain caused from stress, anxiety, humiliation, fear or worry. These types of problems create violent emotions and unbearable mood swings for me; and there are

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[18] Besides all that, treating the emotional trauma experienced by inmates in jail has a force multiplier effect for good for the rest of society. The DOJ has already made note of this. If such a policy was recognized as necessary in order to remain decent, it would help inmates recognize and not act on the desire to lash out later when they've been released and they have the chance to once again choose for themselves how they behave. Isn't this kind of understanding part of the social contract that the *Equal Protection Clause* is supposed to protect?

always consequences I have to deal with as a result. Knowingly withholding food is deliberate indifference prima facie. Why should knowingly withholding medically necessary medication be treated any differently.

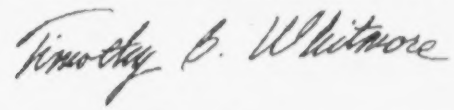
Why is it that the emotional pain I suffered, that was aggravated by being forced by the jail to go without my lithium and quetiapine for (22) days, considered any less of a painful experience than Lance Jett's fractured thumb, that allegedly was brought about by his own clumsiness in falling out of his bunk. In both cases, jail officials knew about the problem, and for whatever reason, delayed rendering treatment. The only difference is that eventually Lance Jett got his thumb fixed, whereas my emotional disorder was evaluated by VA psychiatrists after I left jail, and they determined that it had become permanently worse after I had been forced to go unmedicated while in jail. The causality there can simply not be ruled out, and the material facts for supporting this causality are amply demonstrated by my record.

§ 7. Conclusion

The petition for a writ of certiorari should be granted.

§ 8. Declarations

Under penalty of perjury, I certify that the facts I have presented are true and correct to the best of my knowledge and recollection.



/s/ Timothy B. Whitmore, former LT USCG
Alumni, U.S. Naval Academy

September 3, 2009

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Appendix 1

APPENDIX §1.1

DOCKET 223-1

JUNE 14, 2007

District Judge Robert B. Leighton Presiding
J. Kelley Arnold United States Magistrate Judge

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

Timothy B. Whitmore Plaintiff Pro Se,	
v.	Case No. C05-5265RBL
Pierce County Dept. of Community Corrections et al., Defendants.[1]	Report and Recommendation

This Civil Rights action has been referred to the undersigned Magistrate Judge pursuant to Title

[1] The defendants' attorneys-to-be-noticed were Daniel R. Hamilton for the county defendants and Amanda Marie Migchelbrink for the one state defendant.

28 U.S.C. § 636(b)(1)(B). Before the court are two motions for summary judgment and a cross motion for summary judgment. Defendant Pierce County moves for partial summary judgment and seeks dismissal of the claims in paragraphs 1 to 3.6 of the second amended complaint (Dkt. # 113). Defendant Patricia Brixey moves for Summary Judgment as to all claims involving her (Dkt. # 126). Plaintiff brings a cross motion for summary judgment as to liability for inadequate mental health treatment in his responsive pleading. (Dkt # 212). Defendants have replied (Dkt # 214 to 217). Plaintiff has filed a "declaration" (Dkt. # 218 and 219). This matter is now ripe for review.

FACTS

The family of Jennifer Murphy, a minor female child, obtained an anti harassment order preventing plaintiff from having any contact with her. Plaintiff repeatedly violated that order. In December of 2003, Mr. Whitmore was found guilty of three counts of violating the order. Each count is a gross misdemeanor. Plaintiff was sentenced to one year incarceration with the sentence suspended on certain conditions. Patricia Brixey was assigned as his probation officer. Defendant Brixey works for the Washington State Department of Corrections (Dkt. # 126, 37 to 39).

On October 30, 2004, plaintiff attended a church dance and Jennifer Murphy was present.

Plaintiff sat beside her and spoke to her which violated the restraining order. Defendant Brixey was informed of the violation. Defendant Brixey caused an arrest warrant to be issued. Plaintiff turned himself in and was arrested two days after the dance, on November 1, 2004.

Plaintiff was housed in the Pierce County Jail. During intake at the jail, plaintiff was asked about medical and mental health issues. He informed jail intake staff he had mental health issues, including PTSD and a manic/depressive condition. He informed jail staff he was taking a number of medications for his conditions. The same day he was arrested, jail staff contacted plaintiff's treating facility, the VA hospital, and obtained an "informational RX profile." (Dkt. # 113, Affidavit of Pohl-Y-Baca exhibit b). This document shows multiple prescriptions for Quetiapine in different amounts. One of these prescriptions had been discontinued. There are also prescriptions for Bupropion (Wellbutrin), Lithium Carb., and Levothyroxine (thyroid medication) (Dkt. # 113, Affidavit of Pohl-Y-Baca exhibit b).

Every prescription listed on the informational RX profile as "active", except for Bupropion, showed that plaintiff was given a 90-day supply in June of 2004, and he had not refilled the prescriptions when they should have run out in September of 2004. Thus, jail staff concluded the only active prescription Mr. Whitmore was taking was Bupropion (Wellbutrin). There is a jail clinic entry dated November 2, 2004, stating that medical staff was not able to see Mr. Whitmore that day, 11/2/2004, but

that Bupropion (Wellbutrin) 150 mg would be ordered for him (Dkt. # 113, Pohl-Ybaca exhibit c).

On November 3, 2004, lab work was ordered by Juliette Pohl-Y-Baca, a P.A. In her affidavit this medical provider states the lab work was ordered to determine if it was safe to give the plaintiff thyroid medication, (Levothyrixine) (Dkt. # 113, attached affidavit). On November 3, 2004, jail staff also contacted the VA hospital and received a fax that contained a small amount of additional information. The fax contained information from an October 21, 2004, visit with Dr. Williams. Plaintiff was seen for twenty minutes on this date and expressed a clear desire not to take Lithium (Dkt. # 113 Affidavit of Pohl-Y-Baca exhibit e). Other progress reports were not sent.

Chronological Mental health notes begin on November 3, 2004. Plaintiff was seen at 4:20 P.M. An appointment with a psychiatrist was going to be made. Within eight minutes of the initial entry the mental health provider, Ann Elek, documented an attempt to contact plaintiff's mental health care provider at the VA hospital (Dkt. # 113 Affidavit of Ann Elek, exhibit f). Ms. Elek was not able to reach Dr. Williams at the VA hospital; she did not leave a message. Ms. Elek documented an attempt would be made to reach Dr. Williams "in the future." There is nothing to show any follow up appointment with a psychiatrist was made.

The next entry is a November 17, 2004, contact from Dr. Williams. Dr. Williams states the plaintiff is bipolar and not under control. Dr. Williams states he wouldn't recommend Wellbutrin

at this time and suggested Lithium be restarted with something to help plaintiff sleep. Dr. Williams explains plaintiff was taken off Lithium when he became toxic. An appointment for plaintiff to go to the VA hospital was made for December 14, 2004. Five days after contact was made with Dr. Williams, on November 22, 2004, Lithium was restarted and Wellburtin was discontinued. The November 22, 2004, entry states plaintiff had been becoming more manic and aggressive (Dkt. # 113 Affidavit of Ann Elek, exhibit f). Ms Elek explains the November 17, 2004 contact from Dr. Williams, and states in her affidavit that Dr. Williams "returned a phone call" (Dkt. # 113, Affidavit of Ann Elek). The record does not reflect how many attempts had been made to contact the VA or how many attempts the VA had made to contact jail mental health staff.

On November 12, 2004, plaintiff appeared in Superior Court and was found guilty of violating the conditions of his probation. He was sentenced to 60 days in custody with credit for 12 days served.

While in custody at the Pierce County Jail plaintiff sent a letter to a relative of Jennifer Murphy. The letter was for Jennifer and was delivered to her. The sending of that letter was another violation of plaintiff's conditions of probation. On November 18, 2004, defendant Brixey learned of the letter. She prepared a violation report recommending plaintiff serve the remainder of the year of incarceration from his original sentence. (Dkt. # 113 exhibits). Plaintiff was seen on this new violation on December 3, 2004. The remaining sentence was imposed (Dkt. # 126 exhibits).

In February of 2005, plaintiff's prescription for Lithium expired. Plaintiff had been told to "kite" his health care providers prior to the prescription lapsing. While there was a short lapse in Lithium treatment, there is nothing in the record to show plaintiff suffered any injury as a result of not receiving Lithium in February of 2005.

Defendant Brixey is named as a defendant for her part in revoking plaintiffs probation and for testifying against plaintiff. Plaintiff also challenges conditions of confinement at the jail. The only conditions relevant to Pierce County's partial motion for summary judgment deal with plaintiff's probation hearings, the use of the grievance system, and medical/mental health treatment. Part of plaintiff's claim is an argument that the delusional love letter that resulted in his serving the remainder of his one year sentence would not have been sent had he been placed on Lithium. He alleges Pierce County Jail mental health care providers were deliberately indifferent to his condition.

STANDARD OF REVIEW

Pursuant to Fed. R. Civ. P. 56 (c), the court may grant summary judgment "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with affidavits, if any, show that there is no genuine issue of material fact and that the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56 (c). The moving party is entitled to judgment as a matter of law when

the nonmoving party fails to make a sufficient showing on an essential element of a claim on which the nonmoving party has the burden of proof. Celotex Corp. v. Catrett, 477 U.S. 317, 323 (1985).

There is no genuine issue of fact for trial where the record, taken as a whole, could not lead a rational trier of fact to find for the nonmoving party. Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 586 (1986)(nonmoving party must present specific, significant probative evidence, not simply "some metaphysical doubt."). See also Fed. R. Civ. P. 56 (e). Conversely, a genuine dispute over a material fact exists if there is sufficient evidence supporting the claimed factual dispute, requiring a judge or jury to resolve the differing versions of the truth. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 253 (1986); T. W. Elec. Service Inc. v. Pacific Electrical Contractors Association, 809 F.2d 626, 630 (9th Cir. 1987).

The determination of the existence of a material fact is often a close question. The court must consider the substantive evidentiary burden that the nonmoving party must meet at trial, e.g. the preponderance of the evidence in most civil cases. Anderson, 477 U.S. at 254; T.W. Elec. Service Inc., 809 F.2d at 630. The court must resolve any factual dispute or controversy in favor of the nonmoving party only when the facts specifically attested by the party contradicts facts specifically attested by the moving party. Id.

The nonmoving party may not merely state that it will discredit the moving party's evidence at

trial, in hopes that evidence can be developed at trial to support the claim. T.W. Elec. Service Inc., 809 F.2d at 630. (relying on Anderson, supra). Conclusory, nonspecific statements in affidavits are not sufficient, and "missing facts" will not be "presumed." Lujan v. National Wildlife Federation, 497 U.S. 871, 888-89 (1990).

DISCUSSION

A. Defendant Brixey.

Plaintiff sues defendant Brixey for her part in his probation hearings and alleges a Due Process violation. The allegations in the second amended complaint that are pertinent to this defendant are:

1. Due Process Violations during my Two parole Revocation Hearings that Lead [sic] to Civil Rights Injuries.

1.1 The arraignment Judge Placed Extreme Medical Conditions on My Probation on 5/2/03 that the Jail Could Not Meet Even Though I was Still Subject to Those Terms Until 12/3/2004.

1.2 Denied a Defense Witness that Would Have Made the First Hearing on 11/12/04 Moot.

1.3 The 'Delusional Love Letter' did not violate the State Laws for No Contact Orders. It was not Sent to a restricted party and it had conditional release instructions. (12/03/04)

1.4 The "Delusional Love Letter" was Never Entered into Evidence.

(Dkt. # 30). In an addendum to the second amended complaint plaintiff adds:

1.5 The probation officer misrepresented my Medication compliance at both hearings on 11/12/04 and 12/03/04, as shown by my VA medical record and condensed in my *Original Complaint*. Plaintiff obtained this record directly from a Privacy Act request. The record number for that request is shown in that *Original Complaint*, now referenced as *Preliminary Statement of Fact #1*. I am aware that Privacy Act Requests records meet federal rules of evidence. This probation officer had full access to my records and had told me she was in constant contact with my VA psychiatrist. This effected my due process rights. The probation officers' statements regarding responsibility, and how they relate to effectiveness, viability and culpability, also apply to the jail, the jail's medical clinic, its staff, the medical software they use and the (medical procedures)/(grievance procedures) they follow.

(Dkt. # 31, page 2).

Defendants move for summary judgment on the merits as well as absolute, (witness immunity), and qualified immunity (Dkt. # 126). The court does

not reach the issue of immunity in this case. This is a Civil Rights action brought pursuant to 42 U.S.C. § 1983. When a person confined by the state is challenging the very fact or duration of his physical imprisonment, and the relief he seeks will determine that he is or was entitled to immediate release or a speedier release from that imprisonment, his sole federal remedy is a writ of habeas corpus. Preiser v. Rodriguez, 411 U.S. 475, 500 (1973). In June 1994, the United States Supreme Court held that "[e]ven a prisoner who has fully exhausted available state remedies **has no cause of action under § 1983 unless and until the conviction or sentence is reversed, expunged, invalidated, or impugned by the grant of a writ of habeas corpus.**" Heck v. Humphrey, 512 U.S. 477, 487 (1994)(emphasis added). The court added:

> *Under our analysis the statute of limitations poses no difficulty while the state challenges are being pursued, since the § 1983 claim has not yet arisen. . . . [A] § 1983 cause of action for damages attributable to an unconstitutional conviction or sentence does not accrue until the conviction or sentence has been invalidated.*

Id. at 489. "[T]he determination whether a challenge is properly brought under § 1983 must be made based upon whether 'the nature of the challenge to the procedures [is] such as necessarily to imply the invalidity of the judgment.' *Id.* If the court concludes that the challenge would necessarily imply the invalidity of the judgment or continuing confinement, then the challenge must be brought as a petition for a writ of habeas corpus, not under § 1983."

Butterfield v. Bail, 120 F.3d 1023, 1024 (9th Cir.1997) (*quoting* Edwards v. Balisok, 520 U.S. 641 (1997)).

The allegations against defendant Brixey call into question the propriety of plaintiff's probation revocation hearings and the findings of those two hearings. Plaintiff cannot proceed in a civil rights action until the probation hearings have been successfully overturned in a habeas proceeding.

Plaintiff is no longer in custody. He cannot now file a habeas action. Under 28 U.S.C. § 2254, the district court may entertain an application for a writ of habeas corpus only from a person in custody pursuant to the judgment of a state court. The custody requirement of the habeas corpus statute is designed to preserve the writ as a remedy for severe restraints on individual liberty. Hensley v. Municipal Court, San Jose Milpitas Judicial District, 411 U.S. 345, 351 (1973). The person must be in custody pursuant to the conviction or sentence under attack at the time the petition is filed. Maleng v. Cook, 490 U.S. 488, 490-91 (1989); Carafas v. LaVallee, 391 U.S. 234, 238 (1968).

The Ninth Circuit has held that when a person fails to file a habeas petition while in custody and had an opportunity to file one, a civil rights action may be procedurally barred. Guerrero v. Gates, 442 F.3d 697 (9th Cir. 2006). Here, there is nothing to indicate Mr. Whitmore attempted to challenge his probation hearings in a habeas action. He is no longer in custody, and he is barred from bringing an action challenging the probation revocation proceedings at this point in time. Accordingly, Defendant Brixey

may not be sued for her part in filing probation violation charges or testifying at the probation revocation hearings.

The court does not reach the merits or defendant claims of immunity. Defendant Brixey is entitled to Dismissal and the motion for summary judgment should be **GRANTED** and she is entitled to **DISMISSAL WITH PREJUDICE.**

B. Pierce County.

There are two standards of review employed by the court for this motion.

1. Municipal or County liability.

To establish municipal liability under § 1983, a plaintiff must show that (1) he was deprived of a constitutional right; (2) the municipality has a policy; (3) the policy amounts to deliberate indifference to plaintiff's constitutional rights; and (4) the policy is the moving force behind the constitutional violation. Oviatt v. Pearce, 954 F.2d 1470, 1474 (9th Cir.1992). The Supreme Court has emphasized that the unconstitutional acts of a government agent cannot, standing alone, lead to municipal liability; there is no respondeat superior liability under § 1983. Monell v. New York City Dept. of Social Services, 436 U.S. 658, 692 (1978). A municipality may only be liable where its policies are the "'moving force [behind] the constitutional violation.'" City of Canton v. Harris, 489 U.S. 378, 389, (1989)(quoting Monell at 694).

Here, plaintiff alleges an Eighth Amendment violation and claims County policies and customs

regarding staffing levels and medical practices led to his not receiving constitutionally adequate mental health care. While plaintiff does not specifically identify the policy or practice at issue, his argument survives summary judgment to the extent the court should consider the merits of the claim. See, 3.d below.

2. The Eighth Amendment.

The government has an obligation to provide medical care for prisoners, and the Eighth amendment proscribes deliberate indifference to their serious medical needs. Estelle v. Gamble, 429 U.S. 97 (1976). Such conduct is actionable under 42 U.S.C. § 1983. McGuckin v. Smith, 974 F.2d 1050, 1059 (9th Cir. 1992)(reversed on other grounds by WMX Technologies, Inc. v. Miller, 104 F.3d 1133, (9th Cir. 1997)).

To establish deliberate indifference, a prisoner must show that a defendant purposefully ignored or failed to respond to the prisoner's pain or possible medical need. McGuckin, 974 F.2d at 1060; Estelle, 429 U.S. at 104. A determination of deliberate indifference involves an examination of two elements: the seriousness of the prisoner's medical need and the nature of the defendant's response to that need. McGuckin, 974 F.2d at 1059. A serious medical need exists if the failure to treat a prisoner's condition could result in further significant injury or the unnecessary and wanton infliction of pain. Id.

In order to establish deliberate indifference there must first be a purposeful act or failure to act on the part of the defendant. McGuckin, Id. at 1060.

Appendix 14

A difference of opinion between a prisoner and medical authorities regarding proper medical treatment does not give rise to a section 1983 claim. Franklin v. Oregon, State Welfare Div., 662 F.2d 1337, 1344 (9th Cir. 1981). Mere negligence in diagnosing or treating a medical condition, without more, does not violate a prisoner's Eighth Amendment rights. Hutchinson v. United States, 838 F.2d 390, 394 (9th Cir. 1988). Further, a prisoner can make no claim for deliberate medical indifference unless the denial was harmful. McGuckin, 974 F.2d at 1060; Shapely v. Nevada Bd. of State Prison Comm'rs, 766 F.2d 404, 407 (9th Cir. 1985).

a. Partial Summary judgment.

Pierce County moves for partial summary judgment and asks that the second amended complaint paragraph 1 to 3.6 be dismissed. These paragraphs state:

1). Due Process Violations during my Two Parole Revocations Hearings that Lead [sic] to Civil Rights Injuries.

1.1. The Arraignment Judge Placed Extreme Conditions on my Probation 5/2/03 that the Jail Could Not Meet Even Though I was Still Subject to Those Terms Until 12/3/04.

1.2. Denied a Defense Witness That Would Have Made the First Hearing on 11/12/04 Moot.

1.3. The *'Delusional Love Letter'* Did Not Violate State Laws for no Contact Orders. It was not sent to a restricted party and it had conditional release instructions. (12/3/04).

1.4. The *'Delusional Love Letter'* Was Never Entered into Evidence. (12/3/04).

1.5. The probation officer misrepresented my medication compliance at both hearings on 11/12/04 and 12/03/04, as shown by my VA medical record and condensed in my *Original Complaint*. Plaintiff obtained this record directly from a Privacy Act request. The record number for that request is shown in that *Original Complaint*, now referenced as *Preliminary Statement of Fact #1*. I am aware that Privacy Act Requests records meet federal rules of evidence. This probation officer had full access to my records and had told me she was in constant contact with my VA psychiatrist. This effected my due process rights. The probation officers' statements regarding responsibility, and how they relate to effectiveness, viability and culpability, also apply to the jail, the jail's medical clinic, its staff, the medical software they use and the (medical procedures)/(grievance procedures) they follow.

2). Abuse from the Mishandling of My Prison Grievances.

Appendix 16

2.1. Grievance Mishandling Helped to Deny Me Proper Custodial (Mental Health) Medical Care.

2.2. Procedural Grievance Mishandling Was Used as an Abuse to Avoid Properly Responding to My Petitions.

2.3. Grievance Mishandling Effected My Safety.

2.4. Grievance Mishandling Injured Some of My Other Civil Rights.

3). Abuse from Inadequate Mental Health Treatment by the Jail.

3.1. Inadequate Medical Record Keeping, Screening and/or Support Denied Me Proper Mental Health Care.

3.2. I Did Not Receive Proper Mental Health Treatment Because of the Inadequate Medical (Mental Health) Support Provided by Incompetent, Insufficent [sic] and/or Under Budget Staff.

3.3. Abusive Medication Prescription renewal Procedures that Off Loaded Work and Responsibility Onto Me as an Inmate as a Tacit but Highly Improper Cost-Cutting Strategy.

3.4. Unfair Additional Punishment That Occurred During A period of Diminished Capacity Where that Diminished Capacity Was Created by Inadequate Mental Health Treatment by the Jail.

3.5. Inadequate Mental Health Care that Created Emotional Self Abuse and that Effected Personal Cognitive Thinking, and Intellectual Property Rights.

3.6 I went for (22) days without receiving any of my antipsychotic medications, despite repeated requests.

(Dkt. # 30 and 31).

b. Probation Revocations.

With regard to plaintiff's probation revocations, there is nothing to show Pierce County played any part in that process other than to house plaintiff and transport him to hearings. There simply exists no casual connection between any Pierce County action and the revocations. Further, as noted above, plaintiff may not challenge the revocations in this action.

c. Grievances.

Claims based on Mr. Whitmore's use of the grievance system also fail. The United States Constitution does not mandate that prison officials allow the filing of grievances or that a prison has a grievance system. Mann v. Adams, 855 F.2d 639 (9th

Cir. 1988) Plaintiff has no constitutional right to a grievance process and cannot demand or expect responses to grievances that are to his satisfaction.

This does not mean the grievances may not be relevant to this action. A grievance showing plaintiff placed mental health staff on notice of his conditions or requested treatment is relevant to the issue of whether the mental health staff had knowledge of certain facts.

d. Mental Health Treatment.

Plaintiff alleges it was the policies and customs of the County Jail which led to inadequate treatment of his mental conditions. Analysis as to whether the policies or customs amount to deliberate indifference, and analysis of deliberate indifference in the Eighth Amendment context requires an examination of the merits.

Here, plaintiff allegedly went 21 days, not 22 days as alleged in the complaint, without any anti-psychotic medication. Plaintiff was arrested November 1, 2004 and Lithium was started November 22, 2004. This does not mean the County Jail was deliberately indifferent to plaintiff's mental health condition. On the day of intake, his treatment facility was contacted. Prescription information was obtained and the Jail took steps to obtain the only medication they believed plaintiff was actually taking Bupropion (Wellbutrin). While there were other medications listed as active, plaintiff had not refilled his prescriptions. It was therefore reasonable to assume plaintiff was not currently taking the prescriptions.

Appendix 19

Medical treatment documents, submitted by Mr. Whitmore, reflect his treatment prior to arrest. On August 20, 2004, Dr. Williams at the VA was concerned plaintiff's system may have become toxic because of Lithium. Mr. Whitmore was taken off that drug (Dkt. # 51, page 24). Yet the November 1, 2004, information received by the Jail listed Lithium Carb. as an active prescription. Clearly there were inaccuracies in the prescription information sent on November 1, 2004.

On August 25, 2004, plaintiff's Lithium toxicity level was dropping and Dr. Williams indicated he would consider restarting Lithium next week (Dkt. # 51, page 23). Lithium Carb (Eskalith) 450 mg once a day orally is still listed as an active medication on the August 25, 2004, entry.

Mr. Whitmore was again seen on September 20, 2004. Dr. Williams recommended plaintiff start on Lithium and "warned pt of risk of off Lith." The medication portion of the entry still shows plaintiff taking lithium (Dkt. # 51, page 22). Plaintiff was seen on September 21, 2004, and the entry indicates "continues to feel that w/o lith he is doing better and is happier" The doctor found plaintiff to be "more expansive and animated vs baseline." (Dkt. # 51, page 21). Plaintiff was seen on September 28, 2004 (Dkt. # 51, page 20). Dr. Williams noted plaintiff thoughts were "tangential" and that plaintiff had trouble staying on topic and was upbeat. Dr. Williams noted plaintiff "likes feeling off meds". His assessment was that plaintiff was likely becoming manic. Dr. Williams documented encouraging plaintiff to resume lithium.

The October 5, 2004 entry noted Mr. Whitmore complaining of lack of sleep. Dr. Williams found Mr. Whitmore to have tangential thoughts and loose "assns". Dr Williams assessment was "Mania developing." Again Dr. Williams attempted to get Mr. Whitmore to take lithium and noted "pt resistant at this time." (Dkt. # 51, page 19).

The October 14, 2004 progress note suggests improvement, and for the first time Dr. Williams documents plaintiff to be taking "BDN and Seroquel" (Dkt. # 51, page 18). Dr. Williams noted plaintiff still choosing not to take lithium (Dkt. # 51, page 18). This entry was not provided to Jail officials on November 3, 2004. The final entry before plaintiff's arrest is dated October 21, 2004. It states plaintiff was "resistent [sic] to feed back regarding misinterpretations and insight." The assessment was "BAD, some grandiosity and IOR apparent, though not clearly of a psychotic nature." (Dkt. # 51, page 17). The entry shows Mr. Whitmore still not wishing to take lithium. The October 21, 2004 entry is the only entry provided to Jail officials on November 3, 2004 (Dkt. # 113 Affidavit of Pohl-Y-Baca exhibit e).

The next contact at the VA is dated November 15, 2004. This is a phone call from plaintiff's mother asking if the VA will accept plaintiff for treatment instead of incarceration in the jail. This phone call was taken by Vickie M O'Neal, ARNP. Dr. Williams acknowledged receiving the information from Nurse O'Neal. The information provided to Dr. Williams is that Mr. Whitmore was not getting antipsyhotic [sic] medication and was de-compensating. This entry

contains hearsay. The information is provided as background to the court's discussion and not as evidence to prove the truth of the statement made by Ms. Whitmore or Nurse O'Neal.

The record reflects Dr. Williams contacting Jail officials within two days of his receipt of this message, on November 17, 2004 (Dkt. # 113 Affidavit of Ann Elek, exhibit f). The court cannot determine if this contact was because of Ms. Whitmore's phone call or because of the attempts by Jail staff to contact Dr. Williams. The Jail restarted lithium treatment and discontinued Bupropion (Wellbutrin) at Dr. Williams request. This was done within five days of Dr. Williams contacting the Jail. Further, the Jail medical staff made arrangements for appointments at the VA hospital for Mr. Whitmore on December 14, 2004.

The record does not show the Jail denying, delaying, or interfering with treatment once the Jail was able to ascertain that treatment was in fact needed and currently prescribed. To violate the Cruel and Unusual Punishment Clause, a prison official must have a sufficiently culpable state of mind, that of deliberate indifference to inmate health or safety. Farmer v. Brennan, 511 U.S. 825, 834 (1994). The prison official will be liable only if the official knows of and disregards an excessive risk to inmate health and safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference. Id. at 837.

The Supreme Court has held:

> *It is obduracy and wantonness, not inadvertence or error in good faith, that characterizes the conduct prohibited by the Cruel and Unusual Punishments Clause, whether that conduct occurs in connection with establishing conditions of confinement, supplying medical needs, or restoring official control over a tumultuous cellblock.*

Whitley v. Albers, 475 U. S. 312, 319 (1986). While there was a delay in starting Mr. Whitmore on anti-psychotic medication, plaintiff fails to show the delay was caused by obduracy or wanton behavior. The day of arrest the Jail sought and received some information from the VA hospital. The Jail acted reasonably on the information received. The only medication given to Mr. Whitmore was the one the Jail believed he was actually taking. Further, within two days lab work was started to determine if it was even safe to give plaintiff some of the other medications. Once Dr. Williams spoke to Mental health Staff on November 17, 2004, issues regarding treatment were quickly resolved. While there were delays, Mr. Whitmore fails to show any health care provider acted with a culpable state of mind. Pierce County is entitled partial summary judgement. Claims 1.1 trough 3.6 should be **DISMISSED WITH PREJUDICE**.

C. Mr. Whitmore's Cross Motion and Responsive Pleadings.

In response to defendants motion Mr. Whitmore has moved for summary judgment (Dkt. # 211). Plaintiff also argues this court has expanded the scope of this litigation to include additional conditions of confinement. Plaintiff is in error. When the court indicated this action involved mental health care and general conditions of confinement, the court was referring to the conditions listed by plaintiff in his second amended complaint, not other conditions plaintiff may wish to raise at this point in time (Dkt. # 170).

Much of plaintiff's argument is unsupported by the record and plaintiff draws many improper inferences from the record before the court. By way of example, Mr. Whitmore cites to (Dkt. 186) for the propositions that his father and Dr. Williams called the Pierce County Jail on November 2, 2004, to ensure he received his medications. Review of the documents does not support Mr. Whitmore's factual assertions. The first document is an intake sheet (Dkt. # 186, encl. 1). A notation in the margin shows the name Bruce Whitmore, the date of November 2, 2004, and a phone number. There is nothing to indicate Bruce Whitmore actually called the jail. Further, there is nothing to indicate the substance of any conversation Bruce Whitmore may have had with jail personnel, whom he may have spoken with, or that any of the information he may have given was relayed to a mental health care provider. Mr. Whitmore includes another informational sheet, (Dkt. # 186, encl. 2). He argues the sheet shows Dr.

Williams contacted the Jail on November 2, 2004 to ensure he received medications. The document in question is undated and indicates Dr. Williams called stating plaintiff needs medication. The note is not signed, does not indicate what medication is needed.

At most, plaintiff may show negligence in relaying information or documenting contacts. He does not show any named defendant harbored a culpable state of mind or that the Pierce County Jail has a policy or custom of denying or delaying prescribed medical treatment.

Mr. Whitmore cites an incident that occurred on November 2, 2004 as clear evidence he was in immediate need of mental health treatment. On this date at nearly midnight jail staff had to remove Mr. Whitmore from the shower area (Dkt. # 188-1, page 118). Staff believed Mr. Whitmore may be having an "anxiety attack." Staff contacted medical personnel and learned Mr. Whitmore was scheduled to see medical personnel and that "medication had been ordered." (Dkt. # 188-1, page 118). From other documentation in the record, the court knows Mr. Whitmore was seen the next day, November 3, 2004, and within eight minutes of documenting her contact with him, Ann Elek attempted to contact Dr. Williams. Plaintiff fails to show staff was deliberately indifferent to his medical and mental health needs. (Dkt. # 113 Affidavit of Ann Elek, exhibit f). The court recognizes there could have been better communications between the Pierce County Jail and the VA hospital. Mr. Whitmore may have

received anti-psychotic medication sooner had that communication occurred, but, the County Jail mental health and medical personnel did make attempts to receive information. The record does not support a finding of the type of obdurate or wanton behavior needed to support an Eighth Amendment violation.

Mr. Whitmore has cited to numerous documents he filed during this litigation (Dkt. # 211, page 11 ¶ 67 to 72). The documents in question are statements made by third persons (Dkt. # 141, 146, 159, 174, and 190). Those filings have been objected to. The court allowed the documents to remain in the file, but cautioned that if they were cited to, the opposing party could then raise an objection. Pierce County has objected to the use of the documents in question. (Dkt. # 215). The County argues the documents violate the Federal Rules of Evidence. The Counties position is well taken. Mr. Whitmore's affidavits containing opinions about his mental conditions from laymen violate Fed. R. Evid. 701. The statements are not admissible.

Plaintiff's cross motion for summary judgment should be **DENIED**. A proposed order accompanies this report and recommendation. Pursuant to 28 U.S.C. § 636(b)(1) and Rule 72(b) of the Federal rules of Civil Procedure, the parties shall have ten (10) days from service of this Report to file written objections. *See also* Fed. R. Civ. P. 6. Failure to file objections will result in a waiver of those objections for purposes of appeal. Thomas v Arn, 474 U.S. 140 (1985). Accommodating the time limit imposed by

Rule 72(b), the clerk is directed to set the matter for consideration on **July 11, 2007**, as noted in the caption.

DATED this 14 day of June, 2007.

/S/ J. Kelley Arnold
J. Kelley Arnold
United States Magistrate Judge

Appendix 27

APPENDIX §1.2

DOCKET 236

JULY 19, 2007

District Judge Robert B. Leighton Presiding
J. Kelley Arnold United States Magistrate Judge

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

Timothy B. Whitmore Plaintiff Pro Se,	
v.	Case No. C05-5265RBL
Pierce County Dept. of Community Corrections et al., Defendants.[1]	Order Adopting Report and Recommendation

The Court, having reviewed the Report and Recommendation of Magistrate Judge J. Kelley

[1] The defendants' attorneys-to-be-noticed were Daniel R. Hamilton for the county defendants and Amanda Marie Migchelbrink for the one state defendant.

Arnold, objections to the Report and Recommendation, if any, and the remaining record, does hereby find and ORDER:

(1) The Court adopts the Report and Recommendation;

(2) Defendant Patricia Brixey's motion for summary judgment is **GRANTED**. This defendant is **DISMISSED WITH PREJUDICE**. [*This was the one state defendant*].

(3) Defendant Pierce Counties motion for partial summary judgment is **GRANTED**.

(4) Plaintiff's cross motion for summary judgment as to liability is **DENIED**.

(5) This matter is re-referred to Magistrate Judge J. Kelley Arnold.

(6) The Clerk is directed to send copies of this Order to plaintiff, counsel for defendants, and to the Hon. J. Kelley Arnold.

DATED this 19th day of July, 2007.

RONALD B. LEIGHTON
UNITED STATES DISTRICT JUDGE

Appendix 29

APPENDIX §1.3

DOCKET 252

AUGUST 20, 2007

District Judge Robert B. Leighton Presiding
J. Kelley Arnold United States Magistrate Judge

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

Timothy B. Whitmore Plaintiff Pro Se,	
v.	Case No. C05-5265RBL
Pierce County Dept. of Community Corrections et al., Defendants.[1]	Order Adopting Report and Recommendation

The Court, having reviewed the Report and Recommendation of Magistrate Judge J. Kelley

[1] The defendants' attorney-to-be-noticed was Daniel R. Hamilton.

Arnold, objections to the Report and Recommendation, if any, and the remaining record, does hereby find and ORDER:

(1) Plaintiff's "FRCP [sic] 59 Motion for an Amendment to the Judgment Rendered in Dkt. 223 Regarding the Habeas Corpus Portion of the Complaint" [Dkt. #238] and the amendments thereto [Dkt.#s 243, 244, 245] is considered as a motion for reconsideration of this Court's prior Order adopting the Report and Recommendation dismissing plaintiff's habeas corpus claims and, as such, is **DENIED**.

(2) The Court adopts the Report and Recommendation; (3) Defendant Pierce County's motion for summary judgment as to all remaining claims is **GRANTED**.

(4) Plaintiff's cross motion for summary judgment is **DENIED**.

(5) The Clerk is directed to send copies of this Order to plaintiff, counsel for defendants, and to the Hon. J. Kelley Arnold.

DATED this 20th day of August, 2007.

RONALD B. LEIGHTON
UNITED STATES DISTRICT JUDGE

Appendix 31

APPENDIX §1.4

DOCKET 45

March 12, 2008

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Timothy B. Whitmore Plaintiff-Appellant,	No. 07-35693
v.	D.C. No. CV-05-05265-RBL-JKA, Western District of Washington
Pierce County Dept. of Community Corrections et al., Defendants-Appellees.[1]	Tacoma ORDER

Before: Thomas G. NELSON and A. Wallace TASHIMA, Circuit Judges.

A review of the record demonstrates that the scope of this appeal must be limited to review of the district court's July 19, 2007 order

[1] The defendants' attorney-to-be-noticed was Daniel R. Hamilton.

adopting the magistrate judge's first report and recommendation. Appellant's August 17, 2007 appeal was timely as to the July 19, 2007 partial dismissal order, but was premature as to the district court's August 20, 2007 order adopting the magistrate judge's second report and recommendation and the August 21, 2007 final judgment. Although the premature appeal of the partial judgment entered by the July 19, 2007 order was cured by the entry of the final judgment, the premature appeal from the July 23, 2007 magistrate judge's report and recommendation was not. *See Fid. & Deposit Co. of Maryland v. City of Adelanto,* 87 F.3d 334, 336 (9th Cir. 1996) (premature appeal from district court's partial dismissal cured by dismissal of remaining parties); *see also Anderson v. Allstate Ins. Co.*, 630 F.2d 677, 680-81 (9th Cir. 1980); *but see Serine v. Peterson*, 989 F.2d 371, 372-73 (9th Cir. 1993) (premature appeal from a magistrate judge's order not cured by subsequent entry of judgment by district court).

Appellant's motion to file a substitute opening brief is granted. The Clerk shall filed the opening brief received on November 16, 2007 and shall strike the opening brief filed on October 2, 2007.

Appellees' motion to file the late answering brief is granted. The Clerk shall file the

answering brief and supplemental excerpts of record received on November 30, 2007.

The Clerk shall strike the reply brief received on November 13, 2007 and the errata thereto received on November 16, 2007 because the reply brief pre-dates the answering brief. The Clerk shall file the reply brief received on December 11, 2007.

The following filings are referred to the panel assigned to hear the merits of this appeal: (1) appellant's November 29, 2007 motion to supplement the record; (2) appellant's December 31, 2007 additional citations; (3) appellant's January 10, 2008 motion to submit new evidence; and (4) appellant's January 10, 2008 motion to supplement the excerpts of record. Any further requests for relief in this appeal will be referred to the merits panel.

No motions for reconsideration, modification, or clarification of this order shall be filed or entertained.

This appeal is ready for calendaring.

Appendix 34

APPENDIX §1.5

DOCKET 87

April 27, 2009

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Timothy B. Whitmore Plaintiff-Appellant,	No. 07-35693
v.	D.C. No. CV-05-05265-RBL-JKA,
Pierce County Dept. of Community Corrections et al., Defendants-Appellees.	MEMORANDUM*
and	
Dr. Halarnakar, et. al., Defendants[1]	

Before: Susan P. GRABER, Ronald M. GOULD and Carlos T. BEA, Circuit Judges

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[1] The defendants' attorney-to-be-noticed was Daniel R. Hamilton.

Appendix 35

Appeal from the United States District Court
for the Western District of Washington
Ronald B. Leighton, District Judge, Presiding

Submitted April 13, 2009**

Timothy B. Whitmore, a former inmate in the Pierce County Jail, appeals pro se from the district court's summary judgment in favor of the Pierce County defendants in his 42 U.S.C. § 1983 action alleging deliberate indifference to his serious medical needs and mishandling of his jail grievances. We have jurisdiction under 28 U.S.C. § 1291. We review de novo, *Toguchi v. Chung*, 391 F.3d 1051, 1056 (9th Cir. 2004), and we affirm.

The district court properly granted summary judgment on the deliberate indifference claim because Whitmore failed to raise a genuine issue of material fact as to whether jail officials were deliberately indifferent to his mental health conditions. See *id.* at 1057 (explaining that prison officials must know of and disregard a substantial risk of serious harm for their conduct to constitute deliberate indifference); see also *Villegas v. Gilroy Garlic Festival Ass'n*, 541 F.3d 950, 957 (9th Cir. 2008) (en banc) ("Because there is no constitutional violation, there can be no municipal liability.").

The district court properly granted summary judgment on the claim alleging mishandling of Whitmore's grievances and "kites" (written

complaints about medical care) because inmates do not have a constitutional right to specific grievance procedures. *See Ramirez v. Galaza*, 334 F.3d 850, 860 (9th Cir. 2003). To the extent Whitmore contends that the alleged loss of his kites supports his deliberate indifference claim, summary judgment was proper because Whitmore failed to raise a triable issue as to whether any jail official intentionally denied or delayed his access to medical care. *See Estelle v. Gamble*, 429 U.S. 97, 104-05 (1976); *Hutchinson v. United States*, 838 F.2d 390, 394 (9th Cir. 1988) (concluding that prisoner could not defeat summary judgment where there was no evidence that prison officials had denied or interfered with medical care).

We do not consider Whitmore's contention that he was denied the right to attend religious worship services because this claim was neither raised in the operative complaint nor adjudicated by the district court. *See Coleman v. Quaker Oats Co.*, 232 F.3d 1271, 1294 (9th Cir. 2001); *see also Bias v. Moynihan*, 508 F.3d 1212, 1223 (9th Cir. 2007) (declining to consider issue raised for the first time on appeal).

Whitmore's remaining contentions are unpersuasive.

All pending motions are denied.

AFFIRMED.

* This disposition is not appropriate for publication and is not precedent except as provided by 9th Cir. R. 36-3.

** The panel unanimously finds this case suitable for decision without oral argument. *See* Fed. R. App. P. 34(a)(2).

Appendix 38

APPENDIX §1.6

DOCKET 96

June 5, 2009

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Timothy B. Whitmore Plaintiff-Appellant,	No. 07-35693
v.	D.C. No. CV-05-05265-RBL-JKA, Western District of Washington, Tacoma
Pierce County Dept. of Community Corrections et al., Defendants-Appellees.	ORDER
and	
Dr. Halarnakar, et. al., Defendants[1]	

Before: Susan P. GRABER, Ronald M. GOULD and Carlos T. BEA, Circuit Judges

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[1] The defendants' attorney-to-be-noticed was Daniel R. Hamilton.

The full court has been advised of the petition for rehearing en banc and no judge has requested a vote on whether to rehear the matter en banc. *See* Fed. R. App. P. 35.

Timothy B. Whitmore's petition for rehearing en banc is denied.

Whitmore's pending motions and requests are denied.

No further filings will be accepted in this closed case.

Appendix 40

§ 2. State Laws and Regulations Governing Facilities That Are Obligated to Provide Mental Health Care

Under Washington State law, any facility that involuntarily holds someone requiring mental health care for a period greater than 24 hours, is considered an inpatient mental health facility and must abide by the laws and regulations governing mental health facilities. Do distinction is made under Washington law as to whether the mental health inpatient facility is a mental hospital or a jail or prison. *RCW 71.05.050, RCW 71.05.025, RCW 71.05.210.* My complaint contests the constitutionality of the provision regarding jails and prisons in *RCW 71.05.020 (16)* and argues that the *Equal Protection Clause* renders that provision null and void. To this end, I would like to point out that people incarcerated in jails and prisons typically meet the threshold criteria outlined in *RCW 71.05.020 (17), (23)* and *(39)* because that is frequently why people are incarcerated. Furthermore, the DOJ has found that the incidence of mental disorders that meet the criteria for *RCW 71.05.020 (17)* or *(24)* is on the order of 56% of the inmate population.

Even so, the *Equal Protection Clause, Title II to the ADA* and *Tony Goodman ex Rel United States v. Georgia*, require that jails and prisons conform to the regulations in effect that govern all medically necessary mental health care inside involuntary detention facilities operated by state, local or federal

government or under the color of law. For these reasons, the state's definition of what constitutes "detention" uner *RCW 71.05.020 (12)* applies to jails and prisons as well and so this regulation is in contradiction and should take precedence over *RCW 71.05.020 (16)*, which I argue is unconstitutional and needs to be stricken.

The rights of involuntarily detained persons outlined in *RCW 71.05.360* applies to inmates in the state's federal, state and local jails and prisons, as well, with the exception of ¶10 and any other provision of *RCW 71.05.360* that would negatively impact on the demonstrated security of that jail or prison. In other words, the administrative jursidiction under which a jail or prison is operated should not interfere with the constitutional rights of those that are incarcerated there.

Under *WAC 388-865-0500 (1)*, the state poses an alternative definition of what constitutes an Inpatient Evaluation and Treatment Facility. Under this definition any facility that provides *"involuntary inpatient evaluation and treatment services for more than twenty-four hours ... [is an] inpatient evaluation and treatment facility."* This chapter goes on to acknowledge the governing principles of the *Equal Protection Clause* and *Title II to the ADA* in ¶ 2 wherein it states that *"compliance with the regulations in this chapter does not constitute release from the requirements of applicable federal [and] state ... ordinances [and laws]."*

Consequently the regulations that are promulgated under the following state laws also apply to jails and prisons:

RCW 10.77	Criminally Insane – Procedures
RCW 71.05	Mental Illness
RCW 72.23	Public and Private Facilities for the Mentally Ill
WAC 388-865	Community Mental Health and Involuntary Treatment Programs
RCW 74.09.555	Medical assistance -- Reinstatement upon release from confinement — Expedited eligibility determinations. [Medical standards of procedure That apply to public agencies after jail have to apply during jail].

This constitutes the state laws and provisions that outline the legal responsibilities that the state's jails, that are operated by local government, are obligated to comply with. Under these ordinances, the following regulated Standards of Care and Standard Practices Apply to the jail:

1. The [State's] Admitting Criteria Procedure 1.37
2. The Interdisciplinary Treatment Manual for the Psychiatric Evaluation Clinical profile.

3. The Interdisciplinary Treatment Manual for the treatment plan.
4. The Interdisciplinary Treatment Medication Procedure 801 which describes the ordering of medications
5. The Interdisciplinary Medication Procedure 801 which describes the definitions of administering medications.

These regulations represent the set of regulations governing mental health care at the jail.

The specific mental health care regulations that the jail violated in neglecting my bipolar condition and forcing me to go without any of my anti-psychotic medication for (22) days, even though they were made aware of my condition at booking and documented it at the same time, are as follows:

1. State MHD Inpatient Evaluation and Treatment Facility Procedure 1.37, Admission and Medical Stability Criteria:
   1. *Procedure 1.37 § IV.E.3.e: Recognition of Acute Electrolyte Imbalance at Admission;*
   2. *Procedure 1.37 § IV.E.4.d.1,2: Medication Procedure at Admission;*

2. IDT Manual – Guidelines for Psychiatric Assessments
   § 2. Assessment
   § 2.1. Admission Screening Tool
      § 2.1.1. (b): Documenting Evidence of Risk
      § 2.1.1. (d): Treatment Orders at Admission

§ 2.3. Safety Plan: Within 24-48 Hrs. of Admission

§ 2.3.1. Safety Plan Part of Treatment Plan

§ 2.3.3. Safety Plan Reviewed at Each Treatment Planning Session

§ 2.4. (a): Immediate Action Required to Resolve All Problems Identified on Admission Screening Tool

§ 2.6. Admission Clinical Profile – Used to Identify Patient Goals, Interventions, Treatment Needs

§ 2.6.1. Timelines – (a) Admitting Physician within 60 Hours; (b) Attending Psychiatrist Required; (d) Nursing Assessment within 24 Hours

§ 2.6.3. Psychiatric Evaluation

§ 2.6.3. (f): Document Past Psychiatric History; (k): Identify Current Medication;

(l): Mental Status Examination;

(m) Psychiatric Clinical Evaluation – DSM-IV Diagnosis Completed by Admitting Psychiatrist;

(n) Psychiatric Evaluation Addendum

§ 2.6.4. (i): Medical Team Clinical Formulation

§ 2.6.5.a.6: Nursing Assessment, Psychological

§ 2.6.5.e: Identify Problems Associated with Methods of Seeking Approval, Attention

and Recognition, Asking for Help, Ability to Adapt

§ 2.6.5.f: Sexual Orientation, Manner of Relating to Opposite Sex

§ 2.6.5.g: Protection of Self from Perceived/Real Harms; Danger to Self or Others

§ 2.6.5.h: Goal Setting, Problem Solving, Decision Making Skills

§ 2.6.5.i: Problems with Sleep, Compliance With Treatment, Other Sick Role Behaviors

§ 2.6.5.k: Nursing Clinical Formulation, Treatment Planning Issues, Discharge Planning, Community Agency Involvement

§ 2.6.6. Psychosocial Assessment, Identify Specific Behaviors that Lead to Arrest

§ 2.6.6.(f): Patient Assessment, Significant Emotional Events in Patient's Life, Ability to Function in Society, Level of Motivation, Potential for Change

§ 2.6.6.(i) Psychosocial Clinical Formulation

§ 2.6.6.(l) Psychosocial Assessment Addendum

§ 2.6.6.(m) Psyche Eval: Global Appraisal of Individual Needs-Short Screener (GAIN-SS) Exam: (1) This is required by law.

3. IDT Medication Procedure Manual 801: Introduction – Prescription Authority:

Non-Certified Physicians Assistants (PA) must have orders co-signed by a physician within 24 regular working hours.

Successful Completion of the Medication Component of Orientation is Required for All Licensed Nursing Staff and Ward Clerks.

Safety Factors:

§ 1. Clinical Staff are legally responsible for the orders they write. Licensed nursing staff are legally responsible for all medications/treatments administered.

§ 4. Scan orders to pharmacy immediately upon receipt.

§ 7. All patients treated with atypical anti-psychotics are to be monitored and to receive regular fasting glucose testing.

§ 12. All orders, including verbal and telephone orders, must be dated, timed and authenticated by the prescribing practitioner or another practitioner responsible for the care of the patient.

Steps – General Information:
*§ 1.F. **Verbal Orders** are **ONLY** given to licensed nursing staff in emergency situations. **Telephone Orders** are received by licensed nursing staff when the physician, OD or medical staff is unable to*

physically come to the ward. [Licensed nursing staff does not jail staff members such as clinical psychologists].

§ 1. Licensed nursing staff who take a telephone order from a physician must write that order in the chart.

§ 3. Write the Treatment Order on the Treatment Order Sheet.

§6. Flag the Chart for the Attending Physician

§ 1.G. Stop Dates

§ 1. Licensed Nursing Staff Are Responsible to Bring Expiring Medications to Physicians' Attention.

§2. Orders That Expire on a Weekend/Holiday Are to Be Continued Until 0800 on the Next Working Day.

§ 1.K. Pharmacy Staff Review Medication Orders Prior to Entry into the Pysix/MediMAR System.

§ 1.N. New Medication:

¶1. For all anti-psychotic medications, and other psychotropic medications, the attending physician and the ward medical team practitioner complete the Psychotropic Health Care Record at Initial Assessment, 1 month, 3 month, 6 month, 9 month and annual assessments.

¶2. For psychotropic and nonpsychotropic medications, the attending physician and licensed nursing staff monitor the patient's response to the

new medications and gather the patient's perception about the new medication's effectiveness and side effects.
¶4/¶5. Any side effects/adverse reactions are reported to the attending physician and documented in the progress notes.

§ 3. Informed Consent: The Informed Consent form is completed whenever an anti-psychotic, mood stabilizer, anti-depressant, or anti-anxiety medication is prescribed, unless precluded by court order.

§ 4. Checking Orders: A licensed nursing staff member checks all charts at the end of each shift. [Here the state is defining "licensed nursing staff" as nurses who are licensed as RN or higher].

Once again, the jail complied with none of these standards of care. The result was that I did not get my anti-psychotic medication upon admission, nor did I get it for another (22) days thereafter. Incidentally, there is one final thing I should point out that the district court did not understand. That is that in psychiatric parlance the acronym BAD stands for Bipolar Adaptive Disorder. It does not mean "bad" in the usual sense.

What follows are the state's mental health procedure manuals that contain these regulated standards:

Appendix 49

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
EASTERN STATE HOSPITAL
Administration
P.O. Box 800, Maple Street
Medical Lake, WA 99022-0800
Telephone: 509.565.4000
Fax: 509.565.4705

June 19, 2009

Tim Whitmore
250 Raft Island Dr
Gig Harbor, WA 98335

Re: Public Disclosure Request

Dear Mr. Whitmore:

You had made a request for the following documents:

1. The procedures for admitting involuntarily detained persons to inpatient mental health care.
2. The nature, purpose, methods, procedures, and content of the psychiatrist's mental health examination.
3. The regulation regarding creation of a treatment plan.

4. The regulation regarding prescribing and administering medications as soon as possible.
5. The definition of "as soon as clinically possible."

In response to your request, I am providing the following documents:

1. The hospital's admitting criteria procedure 1.37
2. The Interdisciplinary Treatment Manual guidelines for the psychiatric evaluation clinical profile.
3. The Interdisciplinary Treatment Manual guidelines for the treatment plan.
4. The Interdisciplinary Treatment Medication Procedure 801 which describes the ordering of medications
5. The Interdisciplinary Medication Procedure 801 which describes the definitions of administering medications.

Please do not hesitate to contact me if you have any questions.

Sincerely,

Shirley Maike

Shirley Maike
Information Coordinator
Eastern State Hospital

c: Kathi Pugh, Mental Health Division Public Disclosure Coordinator

Appendix 51

EASTERN STATE HOSPITAL PROCEDURE 1.37 ADMISSION AND MEDICAL STABILITY CRITERIA

EASTERN STATE HOSPITAL
MANUAL

TITLE: ADMISSION AND MEDICAL STABILITY CRITERIA NO: 1.37

EFFECTIVE DATE: 9/84
LAST REVIEWED: 11.08

I. PURPOSE

To identify patients who will require hospitalization for observation, evaluation, care, treatment, and control of behavior arising from or related to mental illness. Also, to identify those medical conditions which preclude admission to Eastern State Hospital.

II. SCOPE

All medical and nursing staff.

III. POLICY

Mental illness does not require hospitalization unless one or more of the admission criteria is present (see Procedure).

It is the policy of Eastern State Hospital that all who do not require hospitalization are referred for treatment in a less restrictive setting. This includes routine outpatient care, transitional residential care, partial hospitalization, etc.

Persons seeking admission must be at least 18 years of age. If under age 18, the individual must be legally emancipated or otherwise approved by the Chief Executive Officer. All persons must meet the criteria for admission as outlined under Procedure, and not suffering solely from alcoholism, dementia, drug abuse, or mental retardation.

IV. PROCEDURE

CRITERIA FOR ADMISSION

A. INVOLUNTARY CIVIL COMMITMENT OR VOLUNTARY STATUS (RCW 71.05/72.23) must include:

1. Acute impairment of social, familial, or occupational functions due to mental illness where admission is voluntarily sought and approved by the Regional Support Network (RSN); or

2. Acute impairment of social, familial, or occupational functions due to mental illness where involuntary admission is requested under RCW 71.05 by a Designated Mental Health

Professional (DMHP) and one or more of the following:

a. Gravely disabled: the patient is so severely disabled that he/she is unable to provide for health or safety needs.

b. Dangerous to self, others, or property of others as manifested by threats of, attempted, or actual assaultive or attempted homicidal behavior, suicidal behavior, or destruction of another's property.

3. Need for 24 hour hospital care with skilled psychiatric observation, evaluation, and/or intervention.

4. Lack of availability for psychiatric treatment elsewhere.

B. COMMITMENT UNDER THE CRIMINAL COMMITMENT STATUS, RCW 10.77, which includes:

1. Competency Evaluation
2. Competency Restoration
3. Not Guilty By Reason of Insanity (NGRI)
4. Return from Conditional Release (pursuant to 10.77 RCW).

C. Commitment under a Federal or Native American Tribal court order.

D. Patients who are enrolled with the Division of Developmental Disabilities (DDD) are admitted directly to the HMH ward (with the exception of those admitted for Competency Evaluation). If the admitting physician determines that the patient's condition contraindicates admission to the HMH ward, he/she shall consult with the HMH Program Manager and/or Administrative OD. If the HMH ward has a census of 12, there are to be no admissions of DDD enrolled persons. The admitting physician, in consultation if necessary with the clinical director, Medical Director, CEO and/or Administrative OD, will inform the DMHP that no bed is available for a DDD enrolled person at ESH and other community resources must be utilized. .

E. PSYCHIATRIC MEDICAL CLEARANCE

1. All patients referred for admission to Eastern State Hospital must be medically stable. If any patient requires a general hospital level of care, he/she does not meet the criteria for admission to Eastern State Hospital. It is recommended that each patient receive a physical examination with laboratory tests, such as CBC, CMP and, if indicated, a drug screen and blood alcohol level prior to admission

2. It is the responsibility of the admitting provider (attending physician or OD) to ensure that patients are medically stable prior to

admission. In almost all circumstances, this will involve a physician -to- physician phone consultation. If the medical history indicates any acute or subacute medical problem, it is the admitting provider's responsibility to ensure that all diagnostic screens and tests have been completed and that the patient does not require a general hospital level of care.

3. Contraindications for Admission to Eastern State Hospital

a. Medical condition requiring general hospital level of care;
b. Medical condition requiring services of an emergency department;
c. An imminent terminal medical condition and/or the patient needs hospice level of service;
d. Blood alcohol level above 0.08;
e. Acute electrolyte imbalance;
f. Delirium from any cause – impending DTs, substance abuse, drug overdose, metabolic encephalopathy, head trauma, toxic substances, or any other medical condition;
g. Patient in need of renal dialysis;
h. Patients with a history of acute chest pain and/or shortness of breath who have not had an Emergency Department workup to rule out myocardial infarction, pulmonary embolism, asthma, etc. and have not been stabilized prior to transfer;
i. Patients on continuous IV analgesics or sedatives;
j. Patients on anticoagulants without current

prothrombin time and INR;

k. Diabetic patients without current blood glucose level;

l. Active TB;

m. Weight below 75% of ideal body weight.

4. Communication Requirements for Medical Stability

a. Patients with acute medical conditions must receive a medical evaluation by a physician or medical licensed independent practitioner within the previous 8 hours including appropriate laboratory workup and documented medical stability.

b. Physician to physician discussion is required regarding any patient being transferred from an Emergency Department.

c. Information is sent with the patient but may be faxed prior to the patient's arrival. Legible copies are required of all information obtained by the referring physician and Emergency Department/clinical staff, including medication records from nursing homes or hospitals, copies of advance directives, CODE status, guardianship/POA, and civil commitment papers.

d. Medications

(1) The transferring facility is asked by the ESH staff member communicating with them to send all patient medications with the transporting personnel.

(2) If the patient is on a new medication or a special medication that may not readily be available at ESH during the night or weekend (for example an antibiotic, cardiac medication, inhalers for asthma, etc., or other medication that may not be on the ESH formulary), the transferring facility is asked by the ESH staff member communicating with them to provide a 2-3 day supply of that medication.

V. REFERENCES

RCW 10.77, Criminally Insane-- Procedures
RCW 71.05, Mental Illness
RCW 72.23, Public and Private Facilities for Mentally Ill
WAC 388-865, Community Mental Health and Involuntary Treatment Programs

Appendix 58

IDT MANUAL – ASSESSMENTS (PSYCHIATRIC EVALUATION GUIDELINES)

2. ASSESSMENT

At the time of admission, the admitting physician and RN complete the psychiatric evaluation and nursing assessment portions of the Admission Clinical Profile. In addition, the RN completes the Admission Screening Tool and Educational Needs. Based on the assessments, preadmission information, reason for admission, legal status and current patient behavior/condition, a treatment plan is developed. This includes the Strength/Problem List, Diagnoses Page, Goals and Interventions Pages, and the Patient/Family Participation form.

All assigned disciplines must complete their portion of the Admission Clinical Profile, within specified time guidelines, prior to the 7 day treatment planning session. The strengths and relevant problems identified in these assessments are incorporated into the treatment plan documents. If the patient refuses to cooperate or is unable to participate in an assessment that requires his/her assistance to complete, attempt once per day for three consecutive days until completed; if still not completed, try at least once a week and at each treatment planning session until successful. All attempts and refusals are to be documented on the handwritten assessment form(s) or

a progress note for those assessments that are typed and on the Treatment Plan Review Note (TPRN).

2.1 ADMISSION SCREENING TOOL

The Admission Screening Tool is completed by the admitting nurse at the time of admission or within 24 hours of admission.

This tool is used to determine immediate risk factors and needs related to pain, falls, safe patient handling, self care deficit, nutritional problems, skin breakdown and physical abuse/neglect. Identified areas of concern are further assessed and appropriate action taken. The admitting physician and RN are responsible for initiating referrals, writing treatment orders, initiating supplemental plans of care, and including relevant information in the appropriate treatment plan documents.

2.1.1 Form Completion

a) Addressograph both sides of form.
b) For each risk area: If no or unable to assess, check appropriate box. If evidence of risk present, check yes, and all criteria that apply. Identify action taken.
c) For section "at risk for pain", a pain rating (0-10) **MUST** be completed. If pain rating is "0", mark the "no" box, a Pain Assessment form is not completed and the blank Pain Assessment form in the admission packet is deleted from the chart. If pain rating is 1 or greater, complete a pain assessment to determine if pain needs to be added

to the Strength/Problem List. If patient is unable to verbalize pain rating, complete side 2 of pain assessment form. Observe nonverbal behavior for indications, consider physical illnesses/medical diagnosis, admission information, and/or information from others accompanying patient. After completion of pain assessment, circle the number that best indicates level of pain on the Admission Screening Tool.

d) The admitting RN consults with the admitting physician if the patient is at risk and further action needs to be taken. The admitting physician is responsible to write any needed treatment orders.

e) The admitting RN signs at the bottom of the form with date and time.

2.1.2 **Filing:** The Admission Screening Tool is filed with the 7 day treatment plan section of the chart. At the time of the 7 day treatment plan, the Admission Screening Tool is reviewed for any follow-up needed and signed by the psychiatrist with date and time.

2.2 EDUCATIONAL NEEDS

a) Side one of the Educational Needs form is completed by the admitting RN at the time of admission.

b) This form is used to assess and identify factors which may influence teaching/learning, academic education history, current educational needs, interest in learning/motivation, best learning approach

and family or caregiver education needs.

c) Side two of the Educational Needs form is completed at each treatment planning session by any treatment team member. The attending physician is responsible to ensure completion of this form at each TPS. The treatment team will review progress toward meeting previously identified educational needs, assess current factors which may influence teaching and/or learning, identify current educational needs, and review the treatment plan to incorporate any necessary changes related to patient/family education.

d) If the patient has severe cognitive impairment or is too symptomatic for learning, note in the area provided. Areas for teaching include (but are not limited to): mental illness, symptom management, medications, substance use, medical equipment, discharge needs and options, competency to stand trial, living skills, etc.

• • •

2.3 SAFETY PLAN

The Safety Plan is an assessment completed within 24-48 hours. of admission by the patient with staff assistance if needed. It is also updated regularly for all patients. The patient identifies setting events/triggers or antecedents to fearful, angry, aggressive/ assaultive behavior and calming

deescalating techniques to reduce the need for seclusion or restraint. Follow form guidelines.

2.3.1 The admitting RN/designee encourages the patient to complete the Safety Plan within 24-48 hours of admission. Do not ask the patient to complete this form during the admission process. It may be difficult for a patient to focus on questions related to personal safety preferences when they may be anxious about admission to the hospital. The Safety Plan becomes a part of the treatment plan.

2.3.2 For patients unable to participate in completing the form (e.g. severe cognitive impairment, dementia, head injury, psychosis), staff documents reason in the intervention section for the problem/behavior.

2.3.3 The Safety Plan is reviewed and updated, as appropriate, with the patient at each treatment planning session and following each seclusion/restraint debriefing session.

2.3.4 **Filing:** The Safety Plan is filed in the current treatment plan section of the chart with the Goals & Intervention pages.

2.4 **7 Day TPS:** At the 7 day treatment planning session, the interdisciplinary team members review the data on the Admission Screening Tool, Educational Needs, Safety Plan and other assessment data collected, including pregnancy

test results, if applicable, to ensure accuracy and completeness.

a) All identified problems on the Admission Screening Tool must have appropriate action taken. If "unable to assess" is marked for any risk area, this must be completed prior to or at the 7 day TPS. Document changes, additions, or results on the 7 day TPRN.
b) In the bottom box of the Admission Screening Tool, check box that form was reviewed and any additional action taken. Psychiatrist signs with date/time.
c) Complete appropriate section on Educational Needs for that TPS.
d) Review and update the Safety Plan, if applicable.

• • •

2.6 ADMISSION CLINICAL PROFILE

The Admission Clinical Profile is used to determine appropriate treatment goals and interventions based on identified patient needs/problems/strengths at the time of admission. The Clinical Profile is an interdisciplinary document that strives to reduce duplication.

2.6.1 Timelines

a) Admitting physician: Complete and dictate the Psychiatric Evaluation section at the time of

admission. (Must be completed within 60 hours.)

b) Attending psychiatrist (if NOT admitting physician): Review Psychiatric Evaluation section. Complete Psychiatric Evaluation Addendum Page, as needed.

c) Medical Practitioner: Complete Physical Assessment section within 24 hours of admission, including weekends/holidays. Also complete the Abbreviated Tardive Dyskinesia Scale.

d) Nursing (RN): Complete Nursing Assessment section within 24 hours of admission. The admitting nurse will complete as much as possible, with the RN on the next two shifts adding additional information as needed/available in the Addendum section.

• • •

f) Psychosocial: Complete Psychosocial Assessment section and Gain-SS within seven days of admission.

g) If applicable, other treatment team members complete the discipline specific assessments according to department guidelines.

h) If a patient refuses to provide assessment information or allow completion of an exam, the treatment team member is to approach and retry daily x3 days or until completed. If the patient continues to refuse after 3 days, try again weekly and at each treatment planning session until completed. Until assessment data is completed,

only staff escorted leaves off ward are allowed. Exceptions may be made by the treatment team. Document all refusals.

2.6.2 Abbreviated Assessment

If the patient has been readmitted and the Clinical Profile documents were completed less than 90 days from the current readmission date, an abbreviated assessment may be done: Psychiatric Evaluation, Physical Assessment, and Psychosocial Assessment. The Nursing Assessment and Rehabilitation Assessment portions of the Clinical Profile must be completed in full.

a) A copy of the full assessment (completed within past 90 days) must be included with the abbreviated assessment in the current chart.

b) If the patient has been readmitted more than once since the complete discipline assessment portion of the Clinical Profile was done, an abbreviated assessment may still be completed as long as the full assessment was done less than 90 days from the current readmission.

c) The person completing the abbreviated assessment must ensure a copy is made of the full discipline assessment from the Clinical Profile and put in the current chart with the abbreviated assessment.

(The original full assessment stays in the master chart.)

2.6.3 **Psychiatric Evaluation**

a) Identify date and time evaluation was completed.

b) Print evaluating physician's name.

c) **Identifying data**: Include patient's name, age, sex, race, marital status, number of admissions, legal status and county of origin.

d) **Chief Complaint**: State why patient is here in his/her own Words.

e) **History of Present Illness and Reason for Admission**: Summary of the patient's signs and symptoms, onset, course, duration of illness, intensity/severity of impairment, stressors, treatment and response.

f) **Past Psychiatric History**: Include previous episodes of psychiatric illness, hospitalization history (diagnosis - treatment - response) and outpatient treatment. Include last ESH admission diagnosis and treatment. Document any history of substance abuse. Indicate any history of violence during the past 10 years including suicide attempts or behavior dangerous to others.

g) **Pertinent Family History**: Include pertinent psychiatric and significant medical illness in the family, treatment received, and response to treatment.

h) **Pertinent Educational, Vocational, Occupational and Social History**: Document significant social, peer group and/or environmental issues which impact current illness. Document education, military service, legal history and occupational history.

i) **Medical Concerns**: Indicate active, significant medical conditions or problems. If patient is female and of reproductive age, ask if she is pregnant. Ask and assess for acute and/or chronic pain. Assess for current infectious diseases i.e. HIV, HBV, HCV, MRSA, STD, TB, scabies, etc. Assess for signs of abuse/neglect.

j) **Allergies**: Identify allergies to medicine and food and symptoms of reaction.

k) **Current Medications**: List name, dose, frequency, and duration of use of medications for psychiatric and medical problems.

l) **Mental Status Examination**: Complete all sections of the mental status exam.

m) **Psychiatric Clinical Formulation**: Complete DSM diagnosis (axis I-V), prognosis, patient strengths, significant clinical problems, and

treatment planning issues. Admitting physician signs after proofing the typed dictation.

n) **Psychiatric Evaluation Addendum:** The attending psychiatrist reviews the Psychiatric Evaluation if not the admitting physician. If there is additional information, further assessment, and/or changes in the psychiatric clinical formulation, document in the addendum section. Attending psychiatrist signs and documents date/time when addendum completed.

o) **Abbreviated Psychiatric Evaluation:**

(1) Assessment must address:
- (a) identifying information
- (b) reason for admission
- (c) mental status exam - note changes in mental status from previous psychiatric evaluation. Indicate the positive findings.
- (d) current medications and dosage
- (e) diagnoses

(2) In the dictated psychiatric evaluation for the current admission state that the past psychiatric hospitalization, family history, past personal/social history were reviewed and there were no changes on this admission. (or describe the changes/new information.)

(3) Ensure a copy of the full Clinical Profile:

Psychiatric Evaluation (must have been Completed within the past 90 days from this admission date) is filed with the current abbreviated psychiatric evaluation in the current chart.

2.6.4 **Physical Assessment**

a) Identify admission ward and admission date; date and time physical assessment completed; and date/time of patient refusal(s), if any.

b) Chief Physical Complaint: If patient has an active medical problem, describe using patient's own words. Include date of admission and reason for admission.

c) History of Recent Medical Treatment: Note signs and symptoms, onset, duration and severity of illness, treatment, lab findings, response to treatment, current pain, etc.

d) **Personal Physician**: Include name, city and state, if known, of primary/personal physician in the community.

e) **Past Medical History**:

1) Medical Hospitalization/Surgeries: Indicate dates of previous hospitalization, name of hospital, diagnosis and treatment. Document any operations and dates. Indicate if patient has been advised to have an operation and state reason if it has not been done.

2) Injury/Accident: Note history of head injury; fractures; back, joint, extremity injuries; severe lacerations; other injuries/accidents; residual pain.

3) Other Medical History: Identify other pertinent information related to illnesses, pain, infectious diseases, etc. Also indicate significant past illnesses not needing hospitalization.

4) Medications: Current medications for medical/physical conditions. Herbal /nutritional supplements used.

5) Allergies: Identify reactions to food or medications.

6) Immunizations: Include what immunizations have been given and when. Has patient ever had a positive PPD? Include Hepatitis A, Hepatitis B, Pneumovax, flu, tetanus, other.

7) Menstrual Cycle/Pregnancy: Menarche, cycle regularity, duration of period and date of last period. Include number of pregnancies, complications, cesarean section, number of live births, still births, miscarriages or abortions. Use of birth control methods. Is the patient currently pregnant?

8) High risk behaviors for

HIV/AIDS/Hepatitis: Check all that apply.

f) **Family Medical History:**

Indicate age and health of parents, siblings, children, and age and cause of death if deceased. Also note any family pattern of diseases or frequent occurrence / reoccurrence of diseases.

g) **Review of Systems:**

1) General: Note complaints of weight loss/gain, swelling of glands, or rash, body malaise, extreme tiredness, bleeding tendency, shakiness of hands or legs, acute or chronic pain.

2) HEENT: Pain in the eyes, blurred or double vision, ringing in the ears or difficulty hearing, bleeding or discharge from ears or nose, trouble with the mouth or difficulty swallowing, sinus problems.

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9) Neurological: Fainting spells, blackouts, dizziness, frequent or severe headaches, difficulty walking or speed sensations, loss of feeling in hands or feet, seizure, hyperalgesia, hypalgesia or paralysis.

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h) **Physical Exam:**

Appendix 72

1) Vital Signs: Record height (HT), weight (WT), blood pressure (BP), temperature (T), respiration (R) and pulse (P).

2) General Appearance: Development, nourishment, acute distress, gait, speech, signs of abuse or neglect.

3) Skin: Skin turgor, condition, rash, distinguishing marks (including needle marks), bruises, signs of skin breakdown, nails. Check condition of feet. Identify tattoos.

4) Head: Skull, scalp, hair.

5) Eyes: Gross vision, extraocular movements, eyelids, sclera, cornea, lens, pupillary reaction, fundi.

6) Ears: Gross auditory acuity, external ears, canals, tympanic membrane, results of audiometric exam.

7) Nose: External area, mucosa, septum, and turbinates.

8) Mouth/Throat: Lips, teeth, gums, tongue, tonsils, pharynx.

9) Neck: Range of motion, thyroid, trachea.

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11) Lungs: Percussion, motion, resonance, breath sounds, rales, rhonchi, wheezing, rub.

12) Heart: Pulse, rhythm, rate, thrill, murmur, gallop, rub.

13) Abdomen: Abdominal wall, scars, tenderness, masses, organomegaly, bowel sounds, hernia.

16) Extremities: Color, structure, swelling, muscles, joints, redness, symmetry, edema,

deformity.

17) Back: Posture, scoliosis, kyphosis, lordosis, mobility, tenderness, configuration, mass.

18) Lymph Nodes: Cervical, axillary, inguinal.

19) Vascular: Carotid pulse, radial pulse, femoral pulse, posterior tibial pulse, dorsal pedal pulse, neck and peripheral veins.

20) Neurological:

(a) Cranial Nerves:

I. Odor of _____ perceived and identified bilaterally.

II. Vision:With/without correction (R & L), visual fields are full to confrontation, optic discs are flat and of normal color.

III, IV & VI. Pupils are equal. They react well to light and accommodation.Extraocular movements show full range of motion without nystagmus.

V. & VII. Muscles of facial expression and mastication are full and symmetrical.

VIII. See Ears/Audiometric Exam

IX & X. Uvula moves in midline,

phonation is normal, speech is clear and intelligible.

XI. Movement of head and shoulder is normal.

XII. Tongue does protrude in midline.

(b) Motor: Movements of the upper and lower extremities both proximally and distally are full and symmetrical. Atrophy is not present. Tremors or cogwheeling are not present. Right or left handed.

(c) Reflexes: Biceps, triceps, knee, achilles, Babinski, Romberg.

(d) Sensory: Modalities of trunk and joint senses are present.

(e) Gait/Coordination: Gait is normal, straight away and on turns.

21) Abbreviated Tardive Dyskinesia Screening: Follow form guideline. Check box if within normal limits (WNL) or refer to screening form for abnormalities.

22) Pertinent Lab Findings: Identify if applicable.

i) Medical Team Clinical Formulation: the identification and prioritization of physical care

needs and treatment focus based on the assessment data. Medical practitioner signs when completed.

If the medical practitioner is not a physician, a physician must review the physical assessment data and sign. If there is additional information, further assessment, and/or changes in the medical team clinical formulation, document in the addendum section. The reviewing physician signs and documents date/time when addendum completed.

j) Abbreviated History and Physical Assessment:

1) Assessment must include:
(a) brief physical evaluation - heart, lungs, abdomen, etc.

(b) any new complaints

2) Dictate a brief history and physical. In the dictation state, "Please refer to the attached Clinical Profile: Physical Assessment done on (date) as there are no physical changes noted on this admission." or describe any changes/new information which has occurred.

3) Ensure a copy of the full Clinical Profile: Physical Assessment (must have been completed within the past 30 days from this admission date) is filed with the

current abbreviated physical assessment in the current chart.

2.6.5 **Nursing Assessment**

a) **Regulating factors** (biophysical, social-cultural, family, physical environment, developmental, psychological) Identify issues which impact functioning and/or treatment approaches:

1) biophysical - note physical, sensory, or cognitive impairments.

2) social-cultural - values, religious beliefs, economic, ethnicity, support systems.

3) family - structure, dynamics (include dysfunction, abuse, neglect, etc.).

4) environment - home, neighborhood, work/school.

5) developmental - mental retardation or other developmental disabilities.

6) psychological - hallucinations, delusions, self-esteem, mood or thought processes, coping styles.

b) **Ingestive** (food and fluid intake; substance abuse; ingesting foreign objects): Check usual and current food/fluid intake and nutritional habits. Describe recent changes in usual body

weight. Record special dietary requests/needs, adaptive equipment, and staff assistance to eat and drink. Identify use of substances potentially harmful to health: alcohol, drugs, tobacco, laxatives.

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d) **Affiliative** (communication skills; development and maintenance of relationships). Check descriptors which apply: speech, relationships, interactions with staff and others. Indicate primary language if other than English. Describe any special communication needs: interpreter, sign language facilitator, adaptive equipment (TTY etc.). Describe any special cultural/spiritual needs.

e) **Dependency** (emotional support and security; methods of seeking approval, attention, and recognition; ability/method of getting needs met). Check descriptors which apply. Identify problems associated with methods of seeking approval, attention and recognition; asking for help; ability to adapt to change.

f) **Sexual** (acceptance of gender; manner of relating to opposite and same sex). Consider patient readiness when addressing sexual issues (sexually active, safer sex knowledge, pregnant). Indicate if follow-up needed. List current/past STDs. Identify needs related to gender role identity, sexuality issues, and sexual behavior.

g) **Aggressive/protective** (protection of self from perceived/real harm; danger to self; danger to others; self destructive behavior; other safety risks): Check all descriptors that apply.

Danger to self/others: Indicate current/past problems. Complete lethality assessment tool, if appropriate. Assess for safety/protective measures needed.

Indicate any legal charges, jail holds, court orders, Tarasoff notifications. Identify other safety needs.

h) **Achievement** (mastery of tasks and self help/independent living skills; goal setting; problem solving, decision making). Identify level of assistance needed to complete Activities of Daily Living (ADL's). Check all descriptors that apply. Identify needs related to problem solving, goal setting, and attention span, living skills, and self care.

i) **Restorative** (sleep pattern, recreational activities, sick role). Check all descriptors that apply. Describe problems with sleep, use of sleep aids and routines that are helpful. Describe needs relating to use of medications, compliance with treatment, and other sick role behaviors.

j) **Overall Acuity Rating**: write in overall acuity rating (I-V) based on subsystem information

and assessment of patient.

k) **Nursing Clinical Formulation**: Identify strengths, treatment planning issues, and discharge planning including the patient's concerns, community agency involvement, and safety concerns at home. The admitting RN signs/dates/times when completed.

l) **Addendum**: When the admitting RN is unable to complete the assessment because the patient is unwilling or unable to give information, an RN will attempt at least once during each of the next two shifts for final completion within 24 hours. This information is documented in the appropriate section of the form and initialed. The RN who completes the assessmentidentifies his/her initials with signature, date and time in the "assessing RN" section.

2.6.6 Psychosocial Assessment

a) **Identification**: Identify full name and any aliases, age, date and place of birth, religious affiliation, ethnicity/race, English proficiency and need for interpreter, marital status, date of admission, date of patient's first admission and total number of admissions, county of residence, usual occupation

b) **Reason for Admission/Readmission**: Identify the specific incidents/behaviors that led to the patient's admission/readmission to the hospital. Include a

statement of the patient's own perception as to why he or she was admitted.

If this admission is due to a revocation of a CR or LRA, the reason for the revocation and the specific condition/restriction violations must be addressed.

c) **Resources/Support System**: Include the person's financial resources, including the amount and source if known. Note if private insurance information is available or if there is a protective payee assigned. Indicate living arrangements prior to hospitalization, including address and other residences if known. If the person is coming from a temporary situation, such as another hospital or jail, the living arrangements prior to that should also be noted. Discuss the patient's personal support system including friends, family, significant others, financial and social service agencies, or any other facility or person that the patient feels has been or continues to be helpful.

d) **Legal History/Information**: Identify legal status upon admission/jail hold (involved county); supervision by Department of Corrections DOC including name and phone number of Community Corrections Officer CCO; type, length and conditions of supervision.

e) **Developmental History**: Identify information regarding the person's childhood environment, growth and development. The focus should be primarily on the patient's patterns of socialization

or isolation, friendships or lack of, significant developmental factors such as traumatic events, critical health conditions, etc. It is also essential to address the person's religious background, level of involvement or estrangement, preoccupation, etc. Note cultural issues that have a significant bearing on the patient's day-to-day life.

Identify educational background, including school performance, total education, specialization, etc.

The focus for employment history is primarily on historical pattern, consistency and general field of employment/usual occupation.

The person's marital history includes current status, number of marriages and children.

Include family dynamics and current family constellation, addressing relationships, support or lack of, concerns addressed by or about family, etc. If there are indications of physical, sexual, emotional abuse or neglect, those should also be addressed. Identify patterns of substance abuse within the family (including the patient).

Military background, if any, should be noted and any pattern of legal problems.

Identify any history of substance use including family history and past treatment. Also identify any history of violence to self, others or property.

f) **Patient Assessment**: This section is a key element in the overall psychosocial assessment and clinical profile. This is the social worker's professional evaluation of the information obtained in the assessment and the effects that these events have had on the patient's life and the ability to function on a day to day basis. This would include noting what strengths the patient demonstrates, how he or she views the current circumstances, the patient's degree of motivation for treatment and potential for change.

g) **Patient Strengths**: Identify pertinent strengths (see Appendix A).

h) **Family Assessment**: This should focus on the family, not only as a source of information, but as a potential resource and participant in the planning process. The family's current level of knowledge regarding the patient's illness should be addressed.

i) **Psychosocial Clinical Formulation**: This section addresses the patient's identified clinical problems from a professional perspective and interventions to address these problems. The interventions should utilize the strengths identified in the patient assessment. A preliminary discharge plan needs to be addressed, with emphasis on finances, living arrangements, support system, aftercare coordination and treatment focus.

j) **Sources of Information:** Identify who/where information obtained.

k) Sign the typed copy and date.

l) **Psychosocial Assessment Addendum:** This section can be used for other clinical information obtained following the completion of the initial assessment and elements that the social worker obtained in the course of the assessment that would be helpful to the other treatment team members' clinical focus. Sign and date addendum section.

m) **Global Appraisal of Individual Needs-Short Screener (GAIN-SS):**

1. As required by state law, the GAIN-SS is used across publicly funded treatment systems to identify prevalence and intensity of co-occurring chemical dependency and mental health disorders. An English, Spanish, and Russian version is available.

2. The social worker asks the person to complete the GAIN-SS during the Psychosocial Assessment process.

    a) If the person will never be able to complete the form (i.e., dementia), mark appropriate box and send form to QM.
    b) If s/he refuses, mark appropriate box and

retry at 7 day TPS.

3. At the 7 day TPS, if the GAIN-SS is completed, it is scored by the physician and social worker to determine quadrant rating.

4. The social worker sends a copy of the form to QM and the original is filed in the assessment portion of the chart.

n) **Abbreviated Psychosocial Assessment:**

1. Refer to Social Work Department Manual Policy #2.19 for specific guidelines

2. Complete:
   - (a) Identification Information
   - (b) Reason for Admission /Readmission
   - (c) Change in Circumstances since Last Admission
   - (d) Resource Systems
   - (e) Legal History/Information
   - (f) Patient Assessment
   - (g) Patient Strengths
   - (h) PsychosocialClinical Formulation
   - (i) Sources of Information

3. In the dictation state: "Please refer to the attached Clinical Profile: Psychosocial Assessment completed on (date) for developmental history and family assessment.

There are no changes in this information." (or identify what changes have occurred.)

4. Ensure a copy of the full Clinical Profile: Psychosocial Assessment (must have been completed within the past 90 days from this admission date) is filed with the current abbreviated psychosocial assessment in the current chart.

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2.6.8 Dictation, Typing, Copying, Distributing

a) Psychiatric Evaluation: The admitting physician dictates the psychiatric evaluation at the time of admission and enters a progress note that communicates pertinent information to the treatment team. Dictated tapes are placed in the APU admitting office box or in GPU Secretary's office if the dictation was done at Westlake prior to the end of the shift. All tapes are forwarded to (or picked up) by Medical Records staff each morning. Each tape is logged and then given to the medical transcriptionists.

The transcriptionist types the evaluation by the end of his/her shift. If there are any tapes remaining, they are given to the APU admitting clerk for typing by the end of his/her shift.

If needed, the attending physician dictates an addendum which includes any information that the admitting physician/OD was not able to

ascertain on admission, changes in diagnosis, etc.

After the typed copy is completed, the original document is returned to the dictating staff person for proofing and signature. The dictating staff routes the original document to the ward. The transcriptionist makes three copies. One copy of the assessment is placed in the APU/FSU ward box in Medical Records to be picked up daily by ward staff, one copy for the master chart and one copy remains in the medical record transcription area to be used later in the completion of the discharge summary. All GPU/HMH ward copies are taken immediately to the Eastlake switchboard and Security hand delivers the document as soon as possible to D Pod. The ward clerk files the assessment immediately in the ward chart. Eastlake and Westlake ward clerks (where applicable) are responsible for placing all Admission Clinical Profile documents in the ward chart.

b) **Physical Assessment**: The Medical Practitioner completes the handwritten draft of the physical assessment portion of the Clinical Profile and dictates results. The handwritten draft is filed in the assessment section of the patient's chart. Dictated tapes are forwarded to Medical Records (Westlake patients to GPU Secretary). The handwritten draft AND the typed original are filed in the assessment section of the

patient's chart as part of the Admission Clinical Profile.

c) **Nursing Assessment**: The admitting RN completes the handwritten nursing assessment. After copying the last page of the assessment and sending it to Medical Records the handwritten original is filed in the assessment section of the ward chart as part of the Admission Clinical Profile.

d) **Psychosocial Assessment**: The social worker dictates this section of the Clinical Profile. The dictation tape is sent to the transcriptionist/typist. One copy of the assessment is forwarded to the social work secretary, another copy is forwarded to the Medical Record department. The original is filed in the assessment section of the ward chart as part of the Admission Clinical Profile.

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f) **Dictation Guidelines**

1) State date and time assessment was completed; date and time dictated.
2) Identify yourself by full name and title.
3) Spell out proper names and places (i.e., street/city names, clinics, hospitals).
4) Spell generic medication names or give both generic and trade name.
5) Use form headings only; subheadings, info in parenthesis, etc., are cues for assessing/dictating only.
6) Dictate refusal dates when applicable.

g) **General Typing Issues**: The transcriptionist /typist makes copies of the typed document as needed. The original is forwarded to the dictating staff person for proofing and signature. After the assessment is signed, the dictating staff forwards the signed original to the ward to be filed in the chart. A copy of the assessment is always routed to the Medical Record department for logging and filing in the master chart.

h) **Changes/Corrections of Documents**: Assessing staff are to proof the typed document to ensure accuracy and completeness. Changes made to the content of the document are acceptable. Minor changes may be made in black ink. To delete a word, phrase or sentence, draw a line through it and initial. Any additions must also be initialed. Major changes require retyping and the signer must return the document to the transcriptionist for those changes. After the document is proofed and signed (with date and time, if applicable) forward the document to the ward to be filed in the assessment section of the ward chart.

EASTERN STATE HOSPITAL IDT MEDICATION PROCEDURE MANUAL PROCEDURE 801

EASTERN STATE HOSPITAL IDT MEDICATION PROCEDURE MANUAL

PROCEDURE: MEDICATION/TREATMENT ORDERS: NO.: 801

GENERAL INFORMATION
EFFECTIVE: 1.88
LAST REVISED: 4.09

INTRODUCTORY INFORMATION:

All orders must be within the staff's scope of practice. Only medical staff privileged to do so may write medication orders. Clinical staff who may write treatment orders are the Medical Staff, Registered Nurse, Dietitian, and Pharmacist. Non-certified Physician Assistants (PA) must have orders co-signed by a physician within 24 regular working hours. Physician Assistant Certified (PAC) and ARNP orders do not require a co-signature.

Forensic Therapists, Chaplain, Physical Therapists, Occupational Therapists, Speech Therapist, Audiologist and Recreation Therapists may also write

orders but these orders require co-signature by the physician within 24 regular working hours.

All licensed nursing staff process orders, administer, and record medications and treatments. Successful completion of the medication component of orientation is required for all licensed nursing staff and ward clerks. On wards with MediMAR, the ward clerk processes all orders that don't involve a scheduled or prn medication except injections and treatments. Ward clerks can process injections, MSM, treatments with and without medications, blood glucose orders, "med watch", "crush meds", discharges, and other non medication orders.

PURPOSE:

1. To identify specific standards regarding medication/treatment orders.
2. To identify the process for ordering medications from pharmacy.

SCOPE:

Medical staff, RN, Dietitian, Ward Clerk, LPN, Pharmacist, Forensic Therapist, Occupational Therapist, Physical Therapist, Recreation Therapist, Speech Therapist, Audiologist, Chaplain.

SUPPLIES:

Treatment Orders Sheet
Diabetic Record

Appendix 91

Treatment Record (TR)
Pharmacy Request Form
Medication Administration Record (MAR)
Patient Infection Report
STAT-PRN Record
Immunization Record
Day and Night Report

SAFETY FACTORS:

1. Clinical staff are legally responsible for the orders they write. Licensed nursing staff are legally responsible for all medications /treatments administered. Carefully read the entire order to be processed. Clarify any unclear orders.

2. If an unacceptable/nonapproved abbreviation is used, the prescriber must be notified and the order clarified. Rewrite the order as "Corrected/Verified Order". The order must be corrected before sending it to pharmacy. Written or telephone orders are acceptable to allow the correction/verification.

3. Allergies must be written in red ink on all Treatment Orders Sheets; MARs; Treatment Record (TRs); STAT-PRN Record; Immunization Record; and white name card.

4. Scan orders to pharmacy immediately to facilitate the patient's treatment. This includes

admissions, transfers, temporary visits, new orders, DC orders, discharges, changes in order, etc. To facilitate the process, there is a designated area on each ward where charts with orders needing scanning are placed. No staff member is allowed to remove the chart from this designated area until the order has been scanned by the ward secretary or other designated staff.

5. Vital signs may be ordered by medical staff or RN for new medication orders, as needed. All patients must be carefully monitored for potential adverse reactions when starting a new medication.

6. Always use a number or zero before a decimal point (e.g., 0.8mg). Never use a zero by itself after a decimal point (e.g., 8.0mg).

7. Any patient treated with atypical antipsychotics are monitored for symptoms of hyperglycemia including polydipsia, polyuria, polyphagia and weakness. Patients who develop symptoms of hyperglycemia during treatment with atypical antipsychotics undergo fasting blood glucose testing. Patients with risk factors for diabetes mellitus (obesity, family history, etc.) who are started on atypical antipsychotics undergo fasting blood glucose testing at the beginning of treatment and periodically during treatment.

8. Pharmacy staff immediately call prescriber if drug-drug interaction is dangerous or will potentially compromise respiratory status.

9. Confusing drug names is a common system failure. Many drug names can look or sound like other drug names, which may lead to potentially harmful medication errors. See Appendix A for additional safety factors and a listing of common errors. Current list of Look Alike Sound Alike Meds are posted in each medication room.

10. High Risk medications are: Fentanyl Patch, Clozapine, Warfarin, other anticoagulants and Insulin. Lists are posted in each medication room and a quarterly review of patients receiving these drugs is evaluated by P&T Committee (see Procedure #823).

11. Multidose vials have an expiration date of 28 days once opened. All opened vials must be labeled with the date opened.

12. All orders, including verbal and telephone orders must be dated, timed, and authenticated by the prescribing practitioner or another practitioner responsible for the care of the patient.

13. All medications (prescribed and OTC) brought in on admission must be counted and reconciled by the admitting RN/designated licensed

nursing staff. See Medication Reconciliation #822.

14. When there is an order to discontinue a medication and there is both a scheduled and PRN order, **both** are discontinued unless the order specifies to discontinue either the scheduled or PRN medication.

STEPS:

1. GENERAL INFORMATION:

A. All Treatment Order Sheets must be addressographed and have the ward written on them.

B. Staff writing the first order on the Treatment Orders Sheet, must ensure that allergies are written in **red ink** in the designated area.

C. All medication orders must be **printed** and state the name of the medication, form, dosage/strength, route, frequency of administration, and indication for use.

D. In the problem column, the problem, indication for use or reason for writing the order must be stated. If the problem is on the Strength/Problem List, use the problem title, i.e., "Psychosis". If not on the Strength/Problem List, identify reason for order or reason for the change in order (such as medication side effects). Specify if order is per policy 1.12 or

court order. All orders for lab must have the appropriate medical diagnosis as a reason.

E. Preprinted Admission Orders Sheet must include the patient's height and weight.

F. **Verbal Orders** are **ONLY** given to licensed nursing staff in emergency situations. **Telephone Orders** are received by licensed nursing staff when the physician, OD, or medical staff is unable to physically come to the ward.

(1) The licensed nursing staff who takes a telephone order from a physician **must** write that order in the chart.

(2) All medication orders must be **printed** and include date/time, the drug name, the dosage form (i.e., tablets, capsules, inhalants); the exact strength or concentration; the dose, frequency and route; the purpose or reason for medication/treatment, and any specific instructions for use.

(3) Write the order on the Treatment Orders Sheet. Always read back the entire order for verification of accuracy. Clearly read back the name of the drug and the dosage ordered; request or provide spelling of the medication name and spell out any numbers. (For example, say "one six" instead of "sixteen" to avoid confusion with "60"). Sign at the end of the order "T.O./RB" physician's

name/licensed nursing staff name/title. This indicates "Telephone Order/Read Back verified".

(4) Check chart for allergies to prescribed medication.

(5) NO verbal or telephone orders are allowed for initial authorization of temporary visits (TV) or for discharges. The physician must come to the ward and see the patient prior to writing the order. Exceptions: If the patient is on a 7TV to a hospital/emergency room and is then admitted, a telephone order for a Medical Discharge is allowed. A telephone order may be used to extend or modify a TV order.

(6) Flag the chart for the attending physician. Any verbal/telephone orders must be authenticated (co-signed) by the attending physician/designee within 24 regular working hours.

G. Stop Dates: All medication and treatment orders remain valid and in effect until discontinued either by medical staff or by an automatic stop date. Nursing orders are discontinued by an RN, and dietary orders are discontinued by the clinical dietitian. Both can be discontinued by the attending physician.

(1) Licensed nursing staff are responsible to bring to the appropriate clinical staff's attention, per ward routine, those

medications/treatments which are due to be discontinued because of a 30-day (monthly) review.

(2) Orders for monthly (30-day) medications or treatments which are due to expire on a weekend or holiday, and have not been reviewed by the physician, are continued until 0800 of the next working day following the weekend or holiday. A continuation order must be received from the physician/OD to continue current orders until the next working day (e.g., "continue current meds/tx until (date)"). If an order to continue medi-cations as indicated on the 30 day medication list is not provided/obtained, complete Medication/Treatment Error Report indicating prescribing error, checking box for "30 day review not done".

(3) If patient is on medications with an automatic stop date other than 30 days, and symptoms persist at the end of the course of treatment, notify appropriate medical staff to reassess.

H. **Automatic Stop Dates**: Unless renewed by medical staff or ordered for a specific period of time, medication orders are automatically discontinued as follows (see below for restrictions):

Controlled drugs (including narcotics, Benzodiazepines and non-benzodiazepines (Ambien, Sonata, Chloral Hydrate) used as a hypnotic or PRN)..... 7 days

Antibacterial/Antibiotic/Antifungal medications..... 7 days

All other medications (i.e., anti- psychotics, antidepressants, mood stabilizers, anticoagulants, benzodiazepines if not used as a PRN or hypnotic [insomnia], etc.) ..... next 30day/medication review date

NOTE: All benzodiazepines and nonbenzodiazepines medications used as a hypnotic or prn have an automatic stop date of 7 days, even if the order is written for more than 7 days. All benzodiazepines PRN orders are valid for one month only on 7-day successive orders by the attending psychiatrist. After one month, no 7-day successive PRN or hypnotic orders are allowed but orders may be changed to a scheduled dose.

Exception: Hypnotics and benzodiazepines may be ordered for 30 days for new admissions only (30 day stop date effective for first 30 days of admission).

If a narcotic, antibiotic, anticoagulant, or non PRN/ nonhypnotic benzodiazepine/ nonbenzodiazepine has been ordered for 30 days, the automatic stop date on the 30 day med review will stay at 30 days until changed by the physician (e.g., physician doesn't have

to keep writing "Ativan 2mg po BID x30 days" at each 30 day med review.

I. Administration times for medications/treatments are as follows:

q AM:	0800
BID:	0800 – 2000
TID:	0800 – 1200 – 2000
QID:	0800 – 1200 – 1600 – 2000
5x's daily:	0800 – 1100 – 1400 – 1700 – 2000
bedtime:	2000
nightly:	specific time ordered

Refer to policy 802 Medication/Treatment Orders for other allowed frequencies. The administration time for scheduled injections, excluding insulin, is 1600.

J. NPO orders: If there is a NPO order because of diagnostic testing, illness or other patient condition, the physician/medical practitioner must specifically identify what meds are to be held and for how long. Nursing staff chart meds as "omitted" in MediMAR until the restart date (or NPO is discontinued). If the patient is NPO to see a specialist or is hospitalized for a procedure, a medication reconciliation must be done.

K. Pharmacy staff review Medication/Treatment orders prior to entry into the Pyxis/MediMAR systems. For orders requiring clarification:

(1) A note is typed on the Medication/Treatment

order and scanned back to the originating ward for clarification.

(2) The ward clerk/nursing staff contacts the prescriber so that a clarification can be written and scanned back to the pharmacy. This allows for a written order to be completed in the patient's chart.

(3) Most orders are able to be handled by the process listed in (1) and (2) without adversely impacting patient care. In some cases, however, a clarification may be deemed by the pharmacist to be urgent due to a time sensitive need for patient care. In these cases, in addition to the written request for clarification, the pharmacist pages or calls the prescriber directly. The prescriber is responsible for ensuring completion of the order by written clarification in the patient's chart (e.g. telephone order to nurse or written order by prescriber). Ward clerk/nursing staff scans the completed clarified order to the pharmacy.

(4) Medication/Treatment orders requiringm clarification remain on hold in the Pyxis/MediMAR systems until they have been clarified. Pharmacy staff review all Medication/Treatment orders on hold or that remain to be clarified on a regular basis, and send additional reminders for clarification. A pharmacist calls the prescriber if necessary to ensure that no orders are missed or remain incomplete.

(5) For potential drug-drug interactions or contraindications:

a. pharmacy staff calls prescriber directly when imminent danger or if medication(s) compromises respiratory status.

.b. if danger not imminent, pharmacy notifies licensed nursing staff on ward of potential drug-drug interactions, possible complications.

.c. licensed nursing staff places notice on attending physician's clipboard or notifies OD if after hours/weekends/holiday for review of order.

L. Report: Per ward routine, write the patient's name and indicate new / changed medication /treatment orders on the Day and Night Report. Do not rewrite specific orders.

M. Patient teaching: Medical staff or licensed nursing staff provide information to the patient and/or family as appropriate about the medicine including both the brand and generic names; the dose, route and frequency; the reason for the medication; and possible side effects. Drug monographs are available in English and Spanish on MediMAR.

N. New medication:

(1) For all antipsychotic medications and other psychotropic medications as appropriate, the attending physician, in conjunction with the ward medical team

practitioner, completes the Psychotropic Health Care Record. At the initial assessment, 1 month, 3 month, 6 month, 9 month, and annual assessments, the patient's weight, blood pressure, fasting plasma glucose, and fasting lipid profile are monitored.

(2) For psychotropic and nonpsychotropic medications, the attending physician and licensed nursing staff monitor the patient's response to the new medication(s) and gather the patient's perception about the new medication's effectiveness and side effects. The RN, physician, and medical staff, as appropriate, documents the patient's response and therapeutic effectiveness of the medications in the weekly/monthly summary in the progress notes.

(3) Vital signs must be monitored each shift for the first 48 hours a patient is placed on a Fentanyl Patch (new order) due to the risk of respiratory depression. A nursing order is written to ensure compliance when patients are placed on a Fentanyl Patch for the first time.

(4) Any side effects are reported to the attending physician and documented in the progress notes.

(5) Any adverse reactions are reported to the physician and documented in the progress notes and on the Adverse Drug Reaction Report.

O. **Identifying information:** Two pieces of information **must** be used to identify the patient prior to administering medications. This can be a photograph; ID band with patient's name, hospital number, birthdate; or asking the patient to state his or her name, etc. When verifying the name with the patient, do NOT state the patient's name but ask the patient what his/her name is. "Knowing" the patient does not qualify as one identifier.

2. **Court Ordered Medications:**
When a treatment order is written to give IM medication if the patient refuses the oral dose, write in the problem column on the Treatment Orders Sheet "per policy 1.12" or "per court order" and the expiration date.

3. **INFORMED CONSENT:** The Informed Consent form is completed whenever an antipsychotic, mood stabilizer, antidepressant, or antianxiety medication is prescribed, unless precluded by court order or per ESH Policy 1.12.

A. At the time the physician prescribes one of the medications listed above, he/she discusses with the patient the indications, contraindications, side effects (both serious, and non-serious), expected benefits, and alternatives to taking the medication.

B. At that time, the medication informed consent form is discussed with the patient.

C. If the patient refuses to give informed consent, or is not capable of providing informed consent, the physician considers alternatives and may initiate ESH Policy 1.12 or petition the court for an order for medication if it is deemed to be in the patient's best interest to receive the medication.

D. If the patient gives informed consent, the patient signs and dates in the appropriate sections.

E. The physician enters the information on the medication Informed Consent Form describing the informed consent and the patient's willingness to accept the medication, and signs and dates the progress note section of the form.

F. The physician obtains informed consent and updates the Informed Consent Form

for each change in class of medication. A progress note is required in the physicians' progress note section of the record. Dose changes, changes in medication in the same class, and changes in frequency do not require additional informed consent.

G. The Informed Consent Form is filed in the treatment order section behind the Code Status Form and is not thinned from the patient record.

4. CHECKING ORDERS:

A. A licensed nursing staff or ward clerk on each shift checks all charts before the end of their shift to ensure all new orders have been processed. The person responsible to check orders is identified on the assignment sheet each shift. STAT orders must be processed immediately. If staff is available, continue to process orders until change of shift when possible.

B. The medication nurse is responsible to check for unverified or missed meds in MediMAR before each medication pass and the end of the shift.

C. Licensed nursing staff on the 11-7 shift checks all orders written within the last

24 hours for completeness and accuracy of transcription. This includes checking MediMAR, the MAR, TR, STAT-PRN Record, Diabetic Record, etc., with the Treatment Order Sheet. When check is completed draw a line in red ink across the Treatment Orders page under the last order checked. Date and sign above the line. When needed, the licensed nursing staff:

(1) Processes the order if an order has been missed. If the medication was not obtained, scan the order using Pyxis Connect to Pharmacy.

(2) Completes necessary paper work in order for the patient to receive medication(s) or treatment(s) in a timely manner.

(3) Initiates a Medication/Treatment Error Report.

5. AT THE END OF EACH MONTH:

A. Pharmacy prints new copies of the TR for the next month and distributes to the wards 3-7 days prior to the end of the month or as requested by the ward. "Order date" remains the date when the treatment was originally ordered and

does not get changed to the monthly (30-day) review date. PRINT the backside of each TR from the "P"ublic drive before using.

B. New monthly treatment records are double checked by a licensed nursing staff on 11-7 shift. Staff initials or signs and puts date in the "Checked By" area on all forms. If initials are used, identify in signature box. 11-7 shift licensed nursing staff must check the new monthly forms with all new orders on the Treatment Orders Sheet, prior to implementation on the first day of the new month.

• • •

9. VITAL SIGNS:

A. A copy of the monthly vital signs/BP recordings for all patients is posted in the medication room or attached to the MAR book for reference by the medication nurse. Vital signs taken more frequently than monthly are also included. If patient refuses vital signs, retry daily until obtained.

B. Only vital signs required to be checked prior to administering medications (i.e., pulse for Lanoxin) are recorded on the MAR for that individual patient.

CROSS REFERENCES

Appendix 108

1. IDT Medication Procedure Manual
   - 802 Writing Orders
   - 803 Processing Medication/Treatment Orders
   - 806 Administration of Medications / Treatments
   - 809 Medication/Treatment Error Report
   - 819 MediMAR
   - 821 Adverse Drug Reactions
   - 823 High Risk Medications

2. Infection Control Manual
   MP603 Surveillance of Patient Infections

3. Nursing Department Standard Manual: Vol III Clinical and Equipment Policies and Procedures.
   III.113 Vital Signs

Approved by Pharmacy & Therapeutics Committee:
November 2008

Approved by Medical Executive Committee:
February 2009

Approved by Nursing Leadership: October 2008

§ 3.1. Citations from Mental Health Experts at NIMH

Ross J. Baldessarini, M.D., D.Sc., DLFAPA, FACP, FACNP, FCINP and Frederick K. Goodwin, M.D., former Director NIMH, 'A Citizen's Petition to the U.S. Dept. of Health and Human Services to Reduce the Incidence of Suicides and Attempted Suicides [That Could Have Otherwise Been Prevented with Medication],' Dockets Management Branch, HFA-305, 27 Sept. 2005. See ***Whitmore Appeal Dkt. 14, Lower Court E.R. II Dkt. 188-3 pp. 8-59.***

The following extract is from the study titled above. This study was performed by Dr. Ross Baldessarini, and Dr. Frederick Goodwin, the former Director of NIMH. *E.R. II Dkt. 188-3 pp. 27-30.*

These recognized medical experts compiled a series of studies that had been performed on bipolars. These studies compared the difference between the risk levels exhibited by bipolars when they were on their medication compared to when they weren't. The composition of these studies contain individual studies that, taken all together, utilize every form of scientific comparison known. These studies cover a time period from 1974 to 2005. They were conducted on an ongoing basis by tracking the individual test subjects as medical science improved over that time period. Even so, the results of these studies are remarkably consistent over time and across various demographic groups.

The results of these studies show that a bipolar's risk of harm to self or others, or of contemplating harm to self or others, is on average 5 times greater when the test subject is off their anti-psychotic medication compared to when they are on it. The primary anti-psychotic medication studied was lithium. These studies also showed, that on an individual basis, a bipolar's risk ratio when not being allowed to take their medication could easily exceed 100. They also discovered that a bipolar's risk ratio was greater if they were taken off lithium compared to if they had never been on lithium at all.

These are significant findings and the U.S. Dept. of Health and Human Services and the U.S. Food and Drug Administration have taken note of them. These findings indicate that a bipolar is placed at a significant risk of harm to self or others when they are denied lithium. These findings are so significant that DHHS posted this study on their website for their Center for Mental Health Services immediately after it was published. However, this is not new information. Psychiatrists have been treating bipolars with lithium for over half of a century.

Appendix 111

List of 31 Studies on Bipolars That Were Reviewed Showing Increased Risk of Suicide without Medication

1. Prien et al. 1974*
2. Kay & Pettrson 1977
3. Poole et al. 1978
4. Ahlfors et al. 1981
5. Venkoba-Rao et al. 1982
6. Hanus & Zapletalek 1984
7. Lepkifker et al. 1985
8. Nilsson & Axelsson 1990
9. Modestin & Schwarzenbach 1992
10. Müller-Oerlinghausen et al. 1992
11. Rihmer et al. 1993
12. Felber & Kyber 1994
13. Lenz et al. 1994
14. Sharma & Markar 1994
15. Koukopoulos et al. 1995
16. Nilsson 1995
17. Greil et al. 1996, 1997 a,b*
18. Bocchetta et al. 1998
19. Coppen & Farmer 1998
20. Tondo et al. 1998
21. Bauer et al. 2000*
22. Broderson et al. 2000
23. Kallner et al. 2000
24. Coryell et al. 2001
25. Rucci et al. 2003
26. Bowden et al. 2003*
27. Calabrese et al. 2003*
28. Goodwin et al. 2003
29. Yerevanian et al. 2003

30. Angst et al. 2005
31. Gonzalez-Pinto et al. 2005

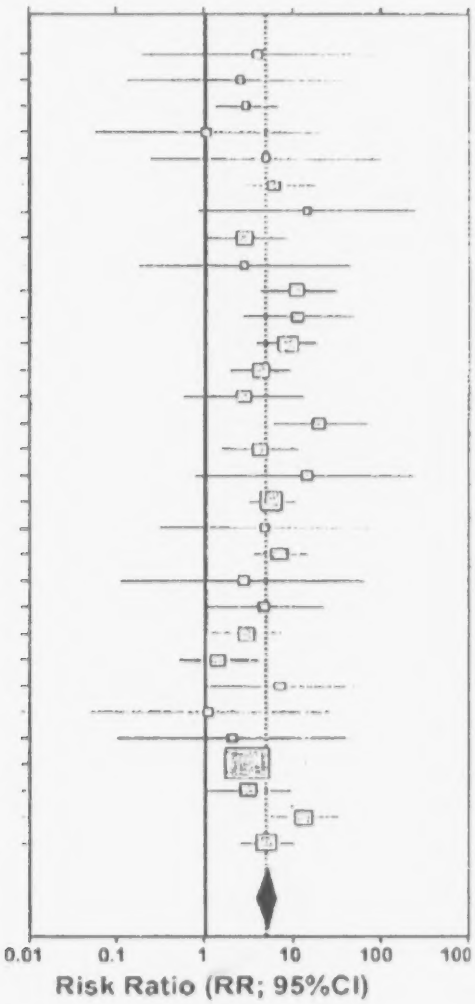

Figure 1:

Pooled Risk Ratio = 4.91. Overall random-effects meta-analysis of 31 studies of risks of suicides and/or attempts, with versus without lithium: RR with

Appendix 113

95%CI for each study (shaded squares proportional to study-weight); computed pooled (black diamond) RR = 4.91 (CI: 3.82Š6.31; z = 12.5, p<0.0001).
[*] = RCTs.

List of 23 Studies on Bipolars That Were Reviewed Showing Increased Risk of Suicide without Medication

1. Prien et al. 1974*
2. Kay & Pettrson 1977
3. Ahlfors et al. 1981
4. Nilsson & Axelsson 1990
5. Modestin & Schwarzenbach 1992
6. Müller-Oerlinghausen et al. 1992
7. Rihmer et al. 1993
8. Felber & Kyber 1994
9. Lenz et al. 1994
10. Sharma & Markar 1994
11. Koukopoulos et al. 1995
12. Nilsson 1995
13. Bocchetta et al. 1998
14. Coppen & Farmer 1998
15. Tondo et al. 1998
16. Bauer et al. 2000*
17. Broderson et al. 2000
18. Kallner et al. 2000
19. Coryell et al. 2001
20. Calabrese et al. 2003*
21. Goodwin et al. 2003
22. Angst et al. 2005
23. Gonzalez-Pinto et al. 2005

Appendix 114

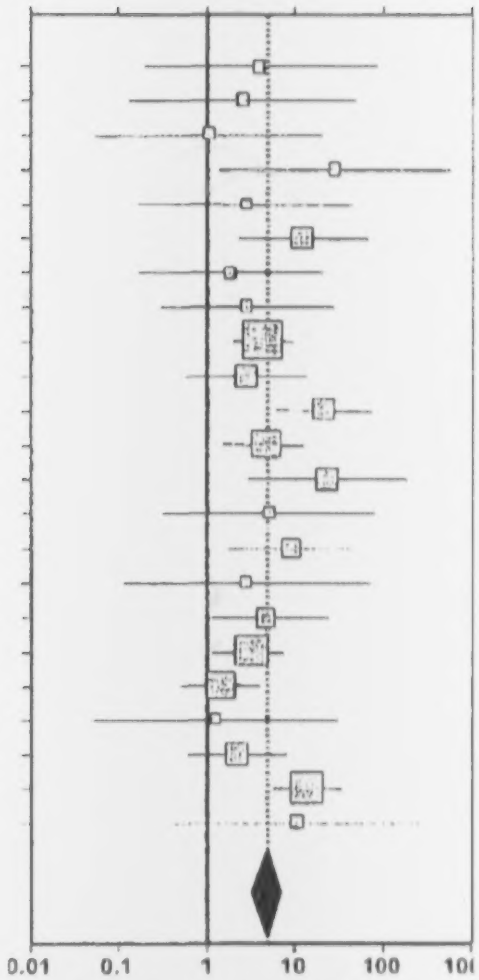

Figure 2:

Pooled Risk Ratio = 4.86. Overall random-effects meta-analysis of 23 studies of risks of suicides, with versus without lithium: RR with 95% CI for each study (shaded squares proportional to study-weight); computed pooled (black diamond) RR = 4.86 (CI: 3.36Š7.02, z=8.42, p<0.0001). [*] = RCT's.

Appendix 115

List of 17 Studies on Bipolars That Were Reviewed Showing Increased Risk of Suicide without Medication

1. Poole et al. 1978
2. Venkoba-Rao et al. 1982
3. Hanus & Zapletalek 1984
4. Lepkifker et al. 1985
5. Nilsson & Axelsson 1990
6. Müller-Oerlinghausen et al. 1992
7. Rihmer et al. 1993
8. Felber & Kyber 1994
9. Greil et al. 1996, 1997 a,b*
10. Bocchetta et al. 1998
11. Tondo et al. 1998
12. Rucci et al. 2003
13. Bowden et al. 2003*
14. Calabrese et al. 2003*
15. Goodwin et al. 2003
16. Yerevanian et al. 2003
17. Gonzalez-Pinto et al. 2005

Appendix 116

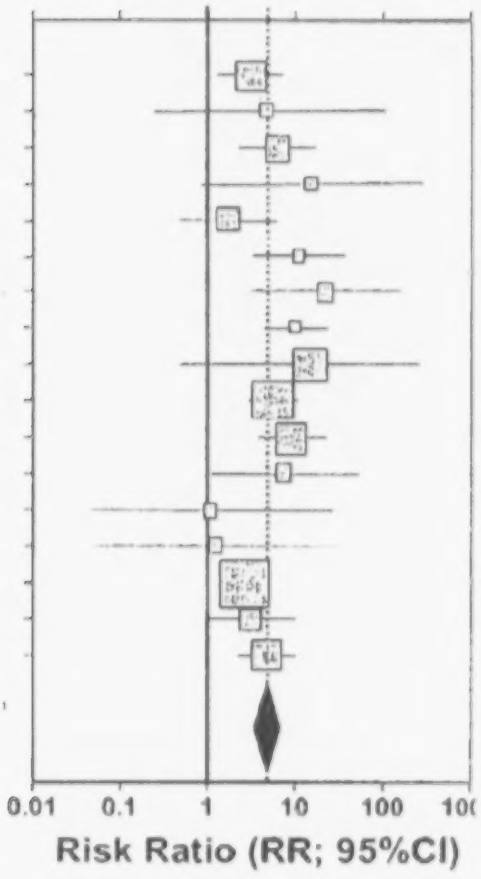

Figure 3:

Pooled Risk Ratio = 4.98. Overall random-effects meta-analysis of 17 studies of risks of suicide attempts, with versus without lithium: RR with 95% CI for each study (shaded squares proportional to study-weight); computed pooled (black diamond) RR = 4.98 (CI: 3.56Š6.96; z = 9.42, p<0.0001). [*] = RCTs.

Meta-analysis: completed and attempted suicide
The pooled estimated RR for *completed suicides* in 23 studies with at least one non-zero numerator was 4.86 (CI: 3.36–7.02; Fig. 2, Table 2), or virtually identical to the pooled estimate of RR (4.91) for all suicidal acts. A similar and highly significant effect of lithium on *suicide attempts* also was detected on the basis of 17 studies (RR=4.98; CI: 3.56–6.96; Fig. 3, Table 2). In these analyses, conservative random-effects modeling was used although preliminary Q-tests indicated nonsignificant heterogeneity of results across studies (for completed suicides: Q [df=22] = 26.5, p=0.23; for attempts: Q [df=16] = 26.2, p=0.051).

Table 2. Summary of meta-analyses: Lithium treatment vs. suicidal risk

Conditions[a]	Studies (N)	*Risk Ratio* RR
All two-armed studies[b]	31	4.91
Omitting Goodwin et al. 2003[b]	30	5.34
Suicides only	23	4.86
Attempts only	17	4.98
Bipolar disorder[c]	14	5.34
Major affective disorders[c]	17	4.66
Quality score ≥50%[d]	16	3.92
Quality score <50%[d]	15	5.56

Conditions[a]	[95%CI]	z
All two-armed studies[b]	[3.82-6.31]	12.5
Omitting Goodwin et al. 2003[b]	[4.27-6.68]	14.7
Suicides only	[3.36-7.02]	8.42
Attempts only	[3.56-6.96]	9.42
Bipolar disorder[c]	[3.59-7.93]	8.28
Major affective disorders[c]	[3.43-6.33]	9.82
Quality score ≥50%[d]	[2.94-5.23]	9.33
Quality score <50%[d]	[3.98-7.76]	10.1

With all p's <0.0001

a. Analyses are based on conservative, random-effects modeling.

b. Results with Goodwin et al. 2003 (58) omitted indicate that this very large study did not exert a misleading influence on the overall findings.

c. For studies with bipolar disorder vs. major affective disorder patient samples: $\chi 2$ (df=1) = 0.91, p=0.34; cases of bipolar I and II disorders and some schizoaffective disorders, in various combinations, are included.

d. For studies with quality ratings (Table 1) at or above vs. below median

§ 3.2. Citations from the Statisticians at the Dept. of Justice:

Doris J. James and Lauren E. Glaze, BJS Statisticians, Bureau of Justice Statistics, "Special Report: Mental Health Problems of Prison and Jail Inmates," U.S. Department of Justice, September 2006, NCJ 213600. See ***Appeal Dkt. 14, E.R. III, Dkt. 109 pp. 12-23.***

The following report was made by the statisticians at the Dept. of Justice. In 2005, they determined that *"more than half of all prison and jail inmates have mental health problems."* This is a policy statement, and as a matter of policy, the DOJ has found that local jails, like the Pierce County Jail, can expect roughly 64% of their inmates to have or to experience mental health problems while they're in jail. This is a serious problem, with liabilities for society at large, and it is not going to go away by ignoring it or neglecting it. *E.R. III Dkt. 109 p. 12.*

Appendix 120

U.S. Department of Justice
Office of Justice Programs

BUREAU OF JUSTICE STATISTICS SPECIAL REPORT

September 2006, NCJ 213600

MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES

Doris J. James and
Lauren E. Glaze
BJS Statisticians

At midyear 2005 more than half of all prison and jail inmates had a mental health problem, including 705,600 inmates in State prisons, 70,200 in Federal prisons, and 479,900 in local jails. These estimates represented 56% of State prisoners, 45% of Federal prisoners, and 64% of jail inmates. The findings in this report were based on data from personal interviews with State and Federal prisoners in 2004 and local jail inmates in 2002.

Mental health problems were defined by two measures: a recent history or symptoms of a mental health problem. They must have occurred in the 12 months prior to the interview. A recent history of mental health problems included a clinical diagnosis or treatment by a mental health professional.

Symptoms of a mental disorder were based on criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV).

	Percent of inmates in --		
Mental Health Problem	State prison	Federal prison	Local jail
Any mental problem	56%	45%	64%
Recent History	24	14	21
Symptoms	49	40	60

More than two-fifths of State prisoners (43%) and more than half of jail inmates (54%) reported symptoms that met the criteria for mania. About 23% of State prisoners and 30% of jail inmates reported symptoms of major depression. An estimated 15% of State prisoners and 24% of jail inmates reported symptoms that met the criteria for a psychotic disorder.

HIGHLIGHTS

High prevalence of mental health problems among prison and jail inmates

	Percent of inmates in State Prison	
Selected Characteristics	With Mental Problem	Without
Criminal Record		
Current or past violent offense	61%	59%
3 or more prior incarcerations	25	19
Substance Dependence/Abuse	74%	56%
Drug use in month before arrest	63%	49%
Family background		
Homelessness year before arrest	13%	6%
Past physical or sexual abuse	27	10
Parents abused alcohol or drugs	39	25
Charged with violating rules*	58%	43%
Physical or verbal assault	24	14
Injured in fight since admission	20%	10%

*Includes items not shown.

Selected Characteristics	Percent of inmates in Local Jail With Mental Problem	Without
Criminal Record		
Current or past violent offense	44%	36%
3 or more prior incarcerations	26	20
Substance Dependence/Abuse	76%	53%
Drug use in month before arrest	62%	42%
Family background		
Homelessness year before arrest	17%	9%
Past physical or sexual abuse	24	8
Parents abused alcohol or drugs	37	19
Charged with violating rules*	19%	9%
Physical or verbal assault	8	2
Injured in fight since admission	9%	3%

*Includes items not shown.

- Nearly a quarter of both State prisoners and jail inmates who had a mental health problem, compared to a fifth of those without, had served 3 or more prior incarcerations.

- Female inmates had higher rates of mental health problems than male inmates (State prisons: 73% of females and 55% of males; local jails: 75% of females and 63% of males).

- About 74% of State prisoners and 76% of local jail inmates who had a mental health problem met criteria for substance dependence or abuse.

- Nearly 63% of State prisoners who had a mental health problem had used drugs in the month before their arrest, compared to 49% of those without a mental health problem.

- State prisoners who had a mental health problem were twice as likely as those without to have been homeless in the year before their arrest (13% compared to 6%).

- Jail inmates who had a mental health problem (24%) were three times as likely as jail inmates without (8%) to report being physically or sexually abused in the past.

- Over 1 in 3 State prisoners and 1 in 6 jail inmates who had a mental health problem had received treatment since admission.

- State prisoners who had a mental health problem were twice as likely as State prisoners without to have been injured in a fight since admission (20% compared to 10%).

§ 3.4. Citations from the Dept. of Justice Civil Rights Division:

Extract from:

Rena J. Comisac, Acting Assistant Attorney General, "Review of the Civil Rights Abuses in the Conditions of Confinement at the King County Correctional Facility, Seattle Washington," Civil Rights Division, U.S. Dept. of Justice, 13 Nov. 2007. See ***Appeal Dkt. 38, Evidence, pp. 1-28.***[1]

Contents:

1. *Appeal Dkt. 38, Evidence p. 2* ..... App. 180-181

Front page of Acting Assistant Attorney General Rena J. Comisac's letter to King County Executive Ronald Sims ordering King County to, inter alia, correct the mental health abuses against the inmates at the King County Jail or face prosecution for constitutional abuses under *42 USC § 1997.b.a.1.* This letter is signed and dated 13 Nov. 2007.

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[1] *"Deliberate indifference may appear 'when prison officials deny, delay, or intentionally interfere with medical treatment, or it may be shown by the way in which prison physicians provide medical care. Jett v. Penner, 439 F.3d 1091, 1096 (9th Cir. 2006)."* From **Appeal Dkt. 38, Summary p. 5.**

2. *Appeal Dkt. 38, Evidence pp 4-5* ..... App. 182-185

This is *Section § II* on the *Legal Standards* applied to the King County Jail by the Dept. of Justice. Paraphrasing, this is where the Attorney General states that deliberate indifference can be shown when a jail delays medical treatment and it may also be shown by the way in which prison doctors provide medical care. Jails and prisons must provide adequate facilities and staff to handle the inmates' medical needs. The letter goes on to state that corrections officials are constitutionally liable when they know or should know of a particular vulnerability of an inmate and then fail to protect the inmate from that vulnerability. These requirements apply to mental health care and, delays in providing medical care, including medication, to an inmate with documented mental health care needs constitutes deliberate indifference.

Hoptowit at 1255 (citing Estelle v. Gamble, 429 U.S. 97, 104 (1976) (quoting Gregg v. Georgia, 428 U.S. 153, 182-83 (1976)). Estelle, 428 U.S. at 103-04. Jett v. Penner, 439 F.3d 1091, 1096 (9th Cir. 2006). Gibson v. County of Washoe, 290 F.3d 1175, 1187 (9th Cir. 2002), (quoting Hoptowit, 682 F.2d at 1252-55). Redman v. County of San Diego, 942 F.2d 1435, 1443 (9th Cir. 1991) (citing Colburn v. Upper Darby Township. 838 F.2d 663, 669 (9th Cir. 1988). Hoptowit, 682 F.2d at 1252-55. Gibson v. County of Washoe, Nev., 290 F.3d 1175, 1190-91 (9th Cir. 2002),

cert. denied, 537 U.S. 1106. Funtanilla v. Rublea, 5 Fed. Appx. 590 (9th Cir. 2001).

3. *Appeal Dkt. 38, Evidence p 20* ..... App. 186-187

This is ***Section § 4***, which is the DOJ's policy page on what constitutes inadequate medication administration and management. Here they declared that the presence of *"systematic problems with medication administration and management"* constitutions a civil rights violation. However, before medication can even be administered or managed, it must be prescribed by a physician. When a jail doesn't have enough prescribers on hand to keep up with the jail population's needs, delays result. The DOJ declares that these delays constitute *"risks of grave harm"* especially when a medication is a *"critical medication"* like how lithium is for bipolars like me. This is what happened to me, and here the DOJ declares that this is an actionable civil rights abuse. As a matter of law, this is something the 9th Circuit overlooked in my case.

4. *Appeal Dkt. 38, Evidence p 24* ..... App. 188-189

This is ***Section § 6***, which is the DOJ's policy page on what constitutes inadequate intake procedures. Here the DOJ states that the screening must be performed by the right kind of medically licensed staff so that serious medical issues, like keeping bipolars medicated, are properly identified and

triaged. Identifying the problem, which is all the Pierce County Jail did in my case, is not enough. The DOJ states that delays in providing necessary treatment or medication during the intake process is unacceptable.

On the very first page of this section, the DOJ cites three instances of inmates who had obvious mental health needs or medication requirements who were ignored and overlooked at intake. Two of these instances involved bipolars just like me. Medication cannot be prescribed until after a medical evaluation by a licensed prescriber takes place. Just like me, one of these inmates was allowed to be placed into housing before being given a psych eval and having psychotropic medication prescribed. This woman ended up having a severe anxiety attack that resulted in "*shaking, vomiting and showing signs of serious malnourishment.*" It is things like this that rob an inmate of his or her dignity. These symptoms are also an indication of a life-threatening condition that's being neglected.

In situations like this, it is not the temporary malnourishment that creates the acute life-threatening condition, it is the dehydration. And, when I started preparing my opening brief for the appeals court, I ended up reliving a lot of unpleasant experiences from my initial unmedicated mental condition when I was taken to the Pierce County Jail. These memories and flashbacks were so severe they provoked an anxiety attack in me that also

resulted in nausea and constant vomiting. After three days of constant vomiting that did not let up, I was so dehydrated that I had to be taken to the emergency room in an ambulance for emergency transfusions of saline solution to rehydrate my body. My medical record shows that I took 3.5 liters of saline solution before I was hydrated sufficiently to urinate, which was my first urination in over 24 hours. That's not good, and all that was required to provoke that anxiety attack was being forced to remember what it was like to be in jail without either of my lithium or quetiapine. See *Appeal Dkt. 34*, generally. For the record, I don't call 911 unless I think I'm dying, and the decision to take me to the hospital was made on scene by the paramedic in charge, not me. *Appeal Dkt. 34.*

5. *Appeal Dkt. 38, Evidence p 25* ..... App. 190

This is the signature page of Attorney General Comisac's order to the King County Jail to straighten up and fly right or face prosecution for civil rights abuses under *42 USC § 1997.b.a.1.*

Appendix 130

U.S. Department of Justice
Civil Rights Division

Assistant Attorney General
950 Pennsylvania Avenue, NW RFK
Washington, DC 20530

November 13, 2007

The Honorable Ron Sims
King County Executie
701 Fifth Ave. Suite 3210
Seattle, WA 98104

Re: King County Correctional Facility, Seattle Washington

Dear Executive Sims:

I write to report the findings of the Civil Rights Division's investigation of conditions at the King County Correctional Facility ("KCCF").[2] On October 30, 2006, we notified you of our intent to conduct an investigation of KCCF pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. As we noted, CRIPA gives the Department of Justice authority to seek a remedy for a pattern or practice of conduct that

[2] The King County Correctional Facility, also referred to as the King County Jail, is located at 500 5th Avenue, Seattle, Washington.

violates the constitutional rights of inmates in adult detention and correctional facilities.

On March 6-8, 2007 and August 1-2, 2007, we conducted on-site inspections at KCCF with expert consultants in corrections and custodial sexual misconduct, medical care and contagious disease prevention and treatment, and suicide prevention. We interviewed security staff, medical staff, administrative staff and inmates. Before, during, and after our visits, we reviewed an extensive number of documents, including policies and procedures, incident reports, investigative reports, grievances from inmates, and staff training materials. In keeping with our pledge of transparency and to provide technical assistance where appropriate, we conveyed our preliminary findings to King County officials at the close of each of our on-site visits.

II. LEGAL STANDARDS

CRIPA gives the Attorney General authority to seek injunctive relief when a jurisdiction violates the constitutional rights of inmates. See 42 U.S.C. § 1977; U.S. Const. amend. VIII, XIV. In defining the scope of jail inmates' Eighth and Fourteenth Amendment rights, the Supreme Court has held that corrections officials must take reasonable steps to guarantee inmates' safety and provide "humane conditions" of confinement. Farmer v. Brennan, 511 U.S. 825, 832 (1994); Bell v. Wolfish, 441 U.S. 520 (1979) (holding pre-trial detainees protected by Fourteenth Amendment); Hydrick v. Hunter, - F.3d -, 2007 WL 2445998 (9th Cir. 2007) (stating right to reasonably safe conditions clearly established for prisoners and civilly committed persons); Hoptowit v. Ray, 682 F.2d 1237, 1250 (9th Cir. 1982). Providing "humane conditions" requires that a corrections system must satisfy inmates' basic needs, such as their need for safety, medical care, food, clothing, and shelter. Id. Additionally, jail officials have a duty to take reasonable steps to protect inmates from physical abuse and the use of excessive force. See Hydrick, 2007 WL 2445998, at *15; Hoptowit, 682 F.2d at 1250.

The duty to protect inmates from physical abuse includes protecting inmates from custodial sexual abuse. Schwenk v. Hartford, 204 F.3d 1187,

1197-98 (9th Cir. 2000) (the Eighth Amendment right of prisoners to be free from sexual abuse has been unquestionably and clearly established.). "'Rape, coerced sodomy, unsolicited touching of women prisoners' vaginas, breasts and buttocks by prison employees are simply not part of the penalty that criminal offenders pay for their offenses against society.'" Schwenk, 204 F.3d, at 1197, quoting Women Prisoners of the Dist. of Columbia Dept. of Corrections, 877 F.Supp.634, 665 (D.D.C. 1994).

The federal courts have also held that the right to "humane conditions" includes a right to adequate medical care. Hoptowit at 1255 (citing Estelle v. Gamble, 429 U.S. 97, 104 (1976) (quoting Gregg v. Georgia, 428 U.S. 153, 182-83 (1976)). Under the Supreme Court's standard for relief, a jurisdiction fails to meet constitutional requirements if local officials exhibit "deliberate indifference" to inmates' serious medical needs. The standard for releif has three components: (1) subjective knowledge of the risk of serious harm; (2) disregard of that risk; and (3) conduct that is more than mere negligence. Farmer, 511 U.S. at 834. The Supreme Court has said that "prison officials show deliberate indifference to serious medical needs if prisoners are unable to make their medical problems known to the

medical staff." Estelle, 429 U.S. at 103-04. The Ninth Circuit has stated that deliberate indifference may appear "when prison officials deny, delay, or intentionally interfere with medical treatment, or it may be shown by the way in which prison physicians provide medical care. Jett v. Penner, 439 F.3d 1091, 1096 (9th Cir. 2006). Moreover, the Ninth Circuit has explained that the "medical staff must be competent to deal with prisoners' problems." Gibson v. County of Washoe, 290 F.3d 1175, 1187 (9th Cir. 2002), (quoting Hoptowit, 682 F.2d at 1252-55) (internal quotation marks omitted). The prison must provide "adequate facilities and staff to handle emergencies within the prison." Id.

Corrections officials may be constitutionally liable when they "know or should know of a particular vulnerability [of an inmate]," such as an inmate in severe emotional distress, and fail to protect the inmate from that vulnerability. Redman v. County of San Diego, 942 F.2d 1435, 1443 (9th Cir. 1991) (citing Colburn v. Upper Darby Township, 838 F.2d 663, 669 (9th Cir. 1988). The prison must provide "adequate facilities and staff to handle emergencies within the prison." Hoptowit, 682 F.2d at 1252-55. Further, these requirements apply to mental health care. Id. Delay in providing hospitalization to a prisoner in need of immediate psychiatric care constitutes deliberate indifference. Gibson v. County of Washoe, Nev., 290 F.3d 1175,

1190-91 (9th Cir. 2002), cert. denied, 537 U.S. 1106. Finally, prison officials have an obligation to act when there is a strong likelihood that an inmate will engage in self-injurious behavior, including suicide. See Funtanilla v. Rubles, 5 Fed. Appx. 590 (9th Cir. 2001).

III. FINDINGS

We find that KCCF fails to adequately protect inmates from harm and serious risk of harm by staff, fails to adequately protect inmates from self harm, and fails to provide inmates with adequate medical care.

A. INADEQUATE PROTECTION FROM HARM

Corrections officials must take reasonable steps to guarantee inmates' safety and provide "humane conditions" of confinement. Providing "humane conditions" requires that a corrections system must satisfy inmates' basic needs, such as their need for safety. Additionally, jail officials have a duty to take reasonable steps to protect inmates from physical abuse.

English. The mental health staff who prescribed medication for her had done so without the use of a translator, even though one was reportedly available by telephone.[3]

In observing this incident, we learned of some unwritten "policies" that, according to security staff, must be followed before a medical nurse may respond to an emergency call. First, a psychiatric nurse must evaluate the inmate, even if the inmate is experiencing clearly life-threatening physical symptoms, like crushing chest pain or hemorrhaging. Second, the page system must be used, even if it would be much faster to summon the nurse from an adjacent medical office or housing unit. These "policies" favor process over provision of critical care of inmates whose lives are at risk.

Moreover, although correctional facilities typically keep logs of inmates they send to hospital emergency rooms, KCCF lacks such logs, making it difficult to ascertain the full extent of the KCCF's deficiencies in this area. We were able to review care for 11 inmates who were sent to the emergency room, however, and found that one of them was forced to wait two days to see KCCF's in-house physician for an infection before finally receiving treatment in the emergency room. This inmate's trip to the

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[3] Since our first tour, DAJD and JHS staff have made increasing use of telephonic translation services.

emergency room may have been prevented altogether if KCCF had provided the inmate with timely care.

4. Inadequate Medication Administration and Management

We found numerous systematic problems with medication administration and management. KCCF places inmates at risk of grave harm through significant delays and lapses in providing critical medications to inmates and the practice of giving nurses "standing orders" to administer antibiotics for skin infections.

First, orders for diagnostic tests and medications are picked up by nursing staff on an inconsistent basis. The failure to perform this important task regularly results in significant delays and lapses in providing critical medications to inmates. For example:

- An HIV-positive inmate who had an abscess was forced to wait 26 days for his first dose of antibiotics and medications for HIV.

wound culture results), and inadequate laboratory testing (few would cultures). Thus, it was not possible for us to determine the full extent of the jail's problem with intramural transmission of skin infections.

6. Inadequate Intake Procedures

Adequate intake procedures are essential for ensuring that inmates are properly screened by staff who are trained to identify and triage serious medical needs. KCCF fails to adequately train and supervise intake staff, and exhibits serious lapses and delays in treatment during its intake process. These failures prevent inmates from receiving adequate treatment for acute or chronic medical needs, placing them at risk of serious harm. For example:

- We witnessed the processing of an inmate who had been stopped by a state trooper. The trooper told us the inmate was staring into space and had been arrested for driving under the influence. The inmate clearly had an altered state of consciousness, either from drugs or psychosis. Neither the intake officer nor the intake nurse recognized this altered state of consciousness. Only after our expert noted the inmate's condition

to several staff members did the inmate receive appropriate monitoring and treatment.

- An inmate who had sustained a sexual assault and was suicidal on intake was seen by psychiatry, but KCCF made no attempt to determine whether she had a sexually transmitted infection or to conduct its own tests.

- We encountered a seriously ill inmate on the women's housing unit, whom the booking officer found had "no observed medical problems." Her medical intake was not completed because the nurse said the inmate was manic and could not be interviewed. Despite the knowledge that the inmate was mentally ill, neither the nurse nor anyone else called for any, much less the necessary immediate, psychiatric or medical evaluation. By the time we observed the inmate on the housing unit, it was evident that she was seriously ill. The inmate was shaking, vomiting, and showing signs of serious malnourishment.

- We witnessed an inmate who reported a history of bipolar disorder. She had been screaming and pounding her fists on the door for two hours in the intake area, yet she had not had a medical screen and no one called for a mental health evaluation.

lawsuit pursuant to CRIPA to correct deficiencies of the kind identified in this letter 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1).

We would prefer, however, to resolve this matter by working cooperatively with you and are confident that we will be able to do so in this case. The lawyers assigned to this investigation will be contacting the facility's attorney to discuss this matter in further detail. If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

/s/ Rena J. Comisac
Rena J. Comisac
Acting Assistant Attorney General

§ 3.5. Citations from the U.S. Senate:

Extract from:

Appeal Dkt. 91 pp. 6-9, quoting from *D.C. Dkt. 165 pp. 13-21.* This is a series of statements made by U.S. senators from the Senate Judiciary Subcommittee on Corrections and Rehabilitation on 8 June 2006. These statements show there is a congressional agenda that recognizes the need to correct the problems with mental health treatment in jails and prisons, as cited in my complaint.

To summarize things, Congress can pass laws but they are not entitled to interpret the U.S. Constitution or its Amendments. That's the Supreme Court's job. Even so, when senators from the Senate Judiciary Committee say that something needs to be done to correct the abuses to the mental health needs of the inmate population, a person should still sit up and take notice. They're senators.

Unfortunately like I said before, senators don't interpret the Constitution. They're supposed to respond to the will of the people, which is not exactly the same thing. It is at this point in the lessons put on by the teachers of secondary school civics classes where they exclaim thank goodness our government has three branches, one of which is the judicial branch.

Even so, the senators that are about to be quoted deserve plenty of credit because they have identified the problem:

"For the vast majority of inmates prison is a temporary, not a final, destination. The experiences inmates have in prison — whether violent or redemptive— do not stay within prison walls, but spill over into the rest of society. Federal, state, and local governments must address the problems faced by their respective institutions and develop tangible and attainable solutions."

— **Senator Tom Coburn** (R-OK), Chair, Senate Judiciary Subcommittee on Corrections and Rehabilitation

"Most of us in Congress and most Americans do not spend a lot of time thinking about the conditions of the prisons across our nation, but we should. We should, because, in the words of the Commission on Safety and Abuse in America's Prisons, 'What happens inside jails and prisons does not stay inside jails and prisons.' And, as the Russian author Fyodor Dostoevsky once reflected, 'The degree of civilization in a society can be judged by entering its prisons.'"

— **Senator Richard J. Durbin** (D-IL), Ranking Member of the U.S. Senate Judiciary Subcommittee on Corrections and Rehabilitation Subcommittee

"As a former prosecutor, I believe strongly in securing tough and appropriate prison sentences for people who break our laws. But it is also important that we do everything we can to ensure that, when these people get out of prison, they enter our communities as productive members of society, so we can start to reverse the dangerous cycles of recidivism and violence. The Commission on Safety and Abuse in America's Prisons has today proposed a set of recommendations to make the country's prisons operate more effectively for the good of the country's prison employees, the prisoners who will be reentering society, and the cities and towns they will be rejoining."

— **Senator Patrick Leahy** (D-VT), Ranking Member of the U.S. Senate Judiciary Committee and Member of the Subcommittee on Corrections and Rehabilitation

"The Commission's report, released today, provides a valuable and candid look at the current state of our nation's jails and prisons, identifying a variety of structural and administrative problems within our corrections system...[and] innovative yet viable recommendations for prison reform that Congress should seriously consider. The comprehensive findings and recommendations in this report are due in large part to the accomplished professionals who make up the Commission itself, and I commend them for their dedication."

— **Senator Russell D. Feingold** (D-WI), Member of the U.S. Senate Judiciary Subcommittee on Corrections and Rehabilitation

The bottomline is that all the laws necessary to correct this problem are already on the books. *Brief, pp. 3-4 n. 3; RCW § 71; WAC 388-865.* They're just not being implemented.

§ 5.6. List of Supplemental Excerpts of Record by Docket Number, Showing Serving Date

S.E.R. No. 1 - Dockets 16, 36, 37: Clarification and Elaboration of the Accepted Standards and Practices for Inpatient Psychiatric Care, As First Shown in *Appeal E.R. I Dkt. 243*, Using Corroborating Information Obtained from a Subdivision of the State's Mental Health Division

..... 4 Oct. 2007, 8 Jan. 2008

S.E.R. No. 2 - Dockets 27, 38: The Department of Justice's Regulations Governing Medical Care for Correctional Facilities, as Reported from their Inspection of the King County Jail

..... 24 Nov. 2007, 14 Feb. 2008

S.E.R. No. 3 - Docket 29: Appellee's Supplemental Excerpt of Record

..... 28 Nov. 2007

S.E.R. No. 4 - Docket 30, 50: Supplemental Excerpt of Record in Reply

..... 8 Dec. 2007

S.E.R. No. 5 - Docket 34: New Evidence of Mental Health Injury from the Pierce County Jail's Neglect of Inmate Mental Health Care

..... 8 Jan. 2008

S.E.R. No. 6 - Dockets 41, 51: The Record of a Previous Civil Rights Lawsuit against the Pierce County Jail, *Sandra Herrera et. al. v. Pierce County et. al., Case No. C95-5025-FDB/JKA* , Filed on 19 Jan. 1995, That Cited the Same Constitutional Violations That Are in My Complaint

..... 22 Feb. 2008, 12 Mar. 2008

S.E.R. No. 7 – Docket 54: Additional Supporting Documents for Answering the Last Two Remaining Questions from the *Herrera* Case Supplement

..... 8 Apr. 2008

S.E.R. No. 8 – Docket 59: Additional Legal Citations to Show that Defendant Pierce County Has Argued and Won a Case against the State for Failure to Provide the Same Constitutionally Mandated Mental Health Care that It Has Denied Its Own Inmates. Thus, the Pierce County Jail Is 'the Pot That Has Called the Kettle Black'

..... 5 May 2008

S.E.R. No. 9 – Docket 60: 3rd Round of Correspondence with Pierce County Sheriff's Dept. Legal Adviser, Additional Evidence from *Public Records Act* Requests

..... 20 May 2008

S.E.R. No. 10 – Docket 63: 5th Round of Correspondence with the Pierce County Sheriff's Dept.; Evidence of Defendants' Financial Malfeasance; Motion for Sanctions under *FRAP 46.c, Circuit Rule 46-2.a, i* and *Advisory Note 46-2.4, 2.8* and *2.9*

..... 14 Jun. 2008

S.E.R. No. 11 – Docket 67: A Study of the Distribution of the Duration of Inmate Stays at the Pierce County Jail as a Means of Determining How Many Psychiatrists Are Needed to Achieve Statutory and Constitutionally Mandated Standards for Mental Health Care

..... 31 Jul. 2008

S.E.R. No. 12 – Docket 69: A Historical Study of the Problems in the Management of the Pierce County Jail's Operating Budget That Have Compromised the Jail's Ability to Provide Sound Mental Health Care

with a View of Identifying Appropriate Injunctive Relief

..... 8 Sep. 2008

S.E.R. No. 13 – Docket 70: Peripheral Documentation for Establishing the Origin of the Records Used in *S.E.R. No. 12* , with Attached *Civil Rule #37* Motion

..... 18 Sep. 2008

S.E.R. No. 14 – Docket 73: The Standards for Mental Health Care for Behavioral and Correctional Facilities, As Promulgated by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO); Motion to Order the Pierce County Jail to Use the JCAHO Accreditation Standards, a *14th Amendment* Equal Protection Clause Interest; Motion to Unseal and Submit the Last Page of the *Herrera* Compliance Monitor's Most Recent Report;

..... 6 Nov. 2008

S.E.R. No. 15 – Docket 78: An Objective Analysis of the Pierce County Jail's Current Mental Health Policies and Procedures Manual; A 'For Information Only' Analysis of the Legal Arguments in Support of Reopening Discovery in the *Herrera* Case

..... 21 Feb. 2009

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09-352

Case No. _____

SUPREME COURT, U.S.
FILED
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OFFICE OF THE CLERK

IN THE

UNITED STATES SUPREME COURT

Timothy B. Whitmore,

Petitioner Pro Se,

v.

Pierce County Department of Community Corrections, et. al.,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit:

SUPPLEMENTAL BRIEF

Timothy B. Whitmore, Pro Se
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§ i. TABLE OF CONTENTS

Page

§ i. TABLE OF CONTENTS ..... i-ii

§ ii. TABLE OF AUTHORITIES ii

1. A MATERIAL FACT CONCERNING THE PIERCE COUNTY SUPERIOR COURT THAT HIGHLIGHTS THE OBVIOUSNESS OF MY COMPLAINT 1-3

2. CORRECTION OF AN INCORRECTLY REPORTED MATERIAL FACT DISCOVERED IN ONE OF THE WESTLAW CITATIONS TO MY CASE 3-6

3. THE REFERENCES FOR *§ 5.2, STATEMENT OF FACT* THAT WERE INADVERTENTLY LEFT OFF THE ORIGINAL *PETITION FOR WRIT OF CERTIORARI* 6-7

4. SUMMARY OF ARGUMENT 8

5. CONCLUSION 8

6. SIGNATURE DECLARATIONS 9

APPENDIX

§1. CITATIONS FROM SPECIAL AUTHORITIES

§ 1.1 Citations from Neuroscientists on Retainer at the Dept. of Justice 1-50

§ ii. Table of Authorities

Pierce County v. State of Washington, 144 Wash. App. 783, 185 P.3d 594; Thurston County Superior Court Case No. 03-2-00918-8 (10 Feb. 2006).

§ 1. A Material Fact Concerning the Pierce County Superior Court That Highlights the Obviousness of My Complaint

This section provides additional information about the inclusion of the Pierce County Superior Court as a defendant that makes the nature of my claim very clear.

I filed a motion (*Dkt. 54*) with the appeals court on 4/11/2008 to eliminate the Pierce County Superior Court from the list of defendants. This motion was denied (*Dkt. 57*) on 4/22/2008. This decision served to maintain the record of the following quote from that court's 12/3/2004 probation revocation hearing:

> THE COUNTY COURT: *"All right. You know, if you have mental health issues you take medication. It's not something you choose to do because if you don't then you'll act out ... When you're out in the community you're to take your medication and apparently when you're in custody you can't do that." Appeal 14/30 E.R. III Dkt. 107-1 p. 68 (D.C. Dkt. 107-1 Tab 3 p. 5).*

This was an odd comment for the county court to have made because I don't need a lecture to take my medication when I'm out on my own. I had been working on a home building project prior to being jailed. Because of the level of physical effort required by that project and the need to maintain my balance and coordination, which was something I had been having trouble with on lithium, I temporarily went

on a quetiapine-only anti-psychotic medication regimen with my VA doctor's recognition.

When I got to jail, my priorities changed. (See *Petition p. 36-37*). I was no longer working hard in construction. The jail lifestyle is quite sedentary in comparison. What I needed was to be able to maintain my emotional balance and my lucidity in the hostile jail environment. That became my first priority, and for that I needed my medication. (See *Petition p. 27.*) I needed to be able to get and take my anti-psychotic medication right away. This was something that the court acknowledged had not happened, but no sua sponte habeas corpus directive proceeded from that recognition. At the time, I did not have the focus to recognize that such a proceeding was needed. All I knew was that I needed my anti-psychotic medication. I didn't care whether the jail psychiatrist put me on a quetiapine-only regimen, a lithium- only regimen or a lithium regimen augmented with quetiapine.

Nevertheless, no medication was provided for (22) days, and this runs contrary to the state regulations health care professionals are supposed to know and follow. I stopped receiving any residual benefit from the quetiapine I had been on prior to being jailed long before my lithium regimen was started back up by the jail psychiatrist.

This explains why my active lithium prescription did not have to be refilled in September 2004. With the two active quetiapine prescriptions I had, this also explains why I still had plenty of quetiapine at the end of October 2004 without having

that prescription refilled yet, either. But all of this is moot.

The state standard of care is to provide the psychiatric exam necessary to begin medication at intake, and not (22) days later. Whether the Pierce County Superior Court is a legitimate defendant or not, the court of appeals' refusal to dismiss them flags additional attention to this case.

§ 2. Correction Of An Incorrectly Reported Material Fact Discovered From the Pivotal Westlaw Citation To My Case

The citation 2007 WL 2116402 (W.D.Wash.) contains several of the district court's crucial errors in the reporting of fact that I wish to correct now. I was not reminded of these errors until I looked up the Westlaw references to my case so that I could provide the section entitled Opinions Below. This was a section that I had originally not provided. I initially didn't provide it because I didn't know what it was until I received additional guidance from the Clerk's Office.

The district court's decision in Docket 223 is what I'm appealing to the Supreme Court. This is the finding to be found at 2007 WL 2116402 (W.D.Wash.). It is dated 7/19/2007.

This citation also contains the cruxt of my complaint and petition to the Supreme Court. The pertinent section is found in Westlaw's reprint of the district court's *Discussion B. Pierce County pp. 6, 10.* Here I assert that county policies failed to meet the

state's regulated standards of care. The primary deficiency was the staffing level for jail psychiatrists. It was so deficient and so abysmally low that the jail failed to provide me with the required psychiatric exam at intake, and things snowballed from there. This is what caused me to go (22) days without my anti-psychotic medication. These claims are supported by the evidence I provided to the appellate court in *Appeal Dkts. 16, 27, 29, 30, 34, 36, 37, 38, 41, 50, 51, 54, 59, 60, 63, 67, 69, 70, 73 and 78.*[1] These comprehensive citations contain the 'specific' policies and practices that are shown to have caused my injuries.

The Westlaw citation goes on to incorrectly state that *"the record does not show the jail denying, delaying or interfering with treatment* ***once the jail was able to ascertain that treatment was in fact needed and currently prescribed,*** *" Westlaw Cit. p. 10.*

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[1] The list of the Supplemental Excerpts of Records (SERs) that I provided to the Appeals Court is found in *Pet. Appendix § 4 pp. 195-198.* All told the 9th Circuit Court of Appeals granted my motions to file (15) Supplemental Excerpts of Record totaling over 2,400 pages. See *Appeal Dkts. 16, 27, 29, 30, 34, 36, 37, 38, 41, 50, 51, 54, 59, 60, 63, 67, 69, 70, 73* and *78* covering a period from 4 Oct. 2007 to 21 Feb. 2009. This is an unbelievable length of time for an Appeals Court to accept new evidence if they didn't think there was something to the case that merited substantive review. Additionally, the Appeals Court ordered the defendants not to object to the filing of these supplements or else they would face sanctions. See *Appeal Dkt. 45* dated 12 March 2008. This is an extremely odd position for the appeals court to have taken if they expected to dismiss the case with nothing more than an unpublished memorandum, and so this serves to flag the case for additional scrutiny.

Here it can be seen that Westlaw is contradicting itself. This contradiction is necessary in order to fully assimilate the court's position. It took the jail (22) days for them to ***"ascertain that treatment was in fact needed and currently prescribed."*** This constitutes an unacceptable delay by any relevant professional mental health standards because it does not meet those standards and no effort was made to try to do so either. See *Pet. App. § 2 pp. 43-48.*

The health care professionals I saw for the first (21) days of my incarceration were limited to one general practice physicians assistant and one psychologist, neither of whom can perform psychiatric exams or prescribe psychotropic medication under Washington state law. These kinds of health care professionals are subordinate to psychiatrists and medical doctors. State regulations require that psychiatric exams and psychiatric prescriptions be provided by psychiatrists or medical doctors at intake, and not by their subordinates. Therefore, the jail's physicians assistant and the jail's psychologist were placed in situations where they were not properly licensed to take appropriate action. This was the cause of the delay, because one part-time jail psychiatrist simply cannot examine all the patients that need to be examined in an inmate population of 1,250.

The importance of requiring properly licensed professionals to be on staff to perform the duties that only they are licensed to perform to maintain state regulated standards of practice is highlighted by the following comparisons: 1. Would you want a bicycle

repairman to perform work on the aircraft engines of the airliners you fly in? Would his understanding and judgment be considered sufficient? 2. Would you accept having a certified nursing assistant perform your brain surgery instead of having it performed by a properly licensed neurosurgeon because the surgeon was unavailable? This, after all would still be considered care by a duly recognized health care professional that was provided without delay.

The answers to these questions are so obvious it begs the question as to why these same expectations regarding licensing standards aren't required in the jail setting as well. Clearly, accepting any of these propositions would be unreasonable. Thus, the deliberate indifference of these propositions is amply demonstrated by their unreasonableness.

§ 3. References for *Section § 5.2 Facts, Pages 6-13* from the *Petition for Writ of Certiorari*

These references were inadvertently left off the original petition. They were supposed to have been included with each numbered ***Fact*** in *Section § 5.2*, but somehow they got deleted from the final version and so here they are:

1. *D.C. Dkt. 186 pp. 7, 11-12.*
2. *Appeal E.R. III Dkt. 114 pp. 5, 9-10.*
3. *Id.*
4. *Id.*
5. *Id.*

6. *Appeal E.R. II Dkt. 188-2 pp. 1-2.*
7. *Id.*
8. *Id.*
9. *Appeal S.E.R. 15 Vol. II pp. 123-126.*
10. *Appeal E.R. I Dkt. 217 p. 2 ¶ 5.*
11. *Pet. Writ. Cert., Appendix § 2.*
12. *Id.*
13. *Appeal S.E.R 11., generally.*
14. *WAC 388-865-0500, RCW 71.05.050.*
15. *Appeal E.R. II Dkt. 188-2 pp. 2,4.*
16. *Id. pp. 1-4.*
17. *Appeal E.R. II Dkt. 188-1 pp. 16-20, 111, 113. Appeal E.R. II Dkt. 188-3 pp. 8-59.*
18. *E.R. II Dkt. 188-1 pp. 111, 113.*
19. *Appeal E.R. II Dkt. 188-2 pp. 1-9.*
20. *Loc. Cit. ¶¶ 17-19 above, Appeal E.R. II Dkt. 188-1 pp. 57-60, 92-104.*
21. *Id.*
22. *Id.*
23. *S.E.R 15 Vol. II pp. 123-126.*
24. *Pet. Writ. Cert., Appendix § 3.1.*
25. *Appeal E.R. II Dkt. 179-1 pp. 11-16.*
26. *Appeal Dkts. 41 and 51, generally.*
27. *Appeal Dkts. 41* and *51.*
28. *Pierce County v. State of Washington*, 144 Wash. App. 783, 185 P.3d 594; Thurston County Superior Court Case No. 03-2-00918-8 (10 Feb. 2006).

§ 4. Summary of Argument

My full argument is found in *Petition § 6*, and so I will simply summarize that argument here.

The failure to require compliance to the regulated standards of care under *RCW 10.77, RCW 71.05, RCW 72.23, WAC 388-865* and *RCW 74.09.555* for the mental health treatment of inmates allows for the violation of those same statutes, in addition to violating the *Equal Protection Clause* in *42 USC § 1983* and *Title II to the Americans with Disabilites Act*. See *App. § 2.2 pp. 43-48*.

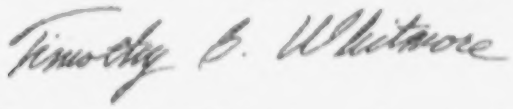
Suggesting that the proof of deliberate indifference requires more than the showing of a failure to comply with regulated standards of care destroys the purpose for having statutorily regulated standards of care.

§ 5. Conclusion

The petition for a writ of certiorari should be granted.

§ 6. Declarations

Under penalty of perjury, I certify that the facts I have presented are true and correct to the best of my knowledge and recollection.



/s/ Timothy B. Whitmore, former LT USCG
Alumni, U.S. Naval Academy

Dated: September 3, 2009

Permanent Address: 250 Raft Island Dr.
Gig Harbor, WA 98335
tel/fax: (253) 265-1710

Appendix 1

§ 1. Citations from Neuroscientists on Retainer at the Dept. of Justice:

Diana Fishbein, Ph.D. performed a study for the U.S. Department of Justice under Contract Award No. 2002-MU-BX-0013, Document No. 216303, in November 2006 entitled, *"Assessing the Role of Neuropsychological Functioning in Inmates' Treatment Response."* See ***Appeal Dkt. 14, E.R. II, Dkt. 179-1 pp. 17-72*** for the full text of that study.

My synopsis of that study is as follows:

Synopsis: Diana Fishbein is a neuroscientist who has published extensively on risk factors in mental health and behavioral disorders and underlying mechanisms in ability to respond favorably to treatment. She and her colleagues were awarded a grant from the Dept. of Justice in 2006 to complete a study that determined that most inmates do not receive necessary treatment and the few who do are unable to respond favorably due to underlying mental and physical deficits. They concluded that there are serious implications in failing to provide proper mental health care to inmates in jail. In common parlance, they proved once again that if you beat a dog it will make it meaner. At the same time, there are numerous reports that incarceration is related to increased severity of mental disorders and contributes to cognitive decline. Thus, neglect by the system for existing mental health disorders can lead to permanent injury, which is a travesty given that effective treatments are available. It was in this

context that these neuroscientists funded by DOJ discovered that failing to provide proper mental health care to inmates who need it has the same effect in lowering an inmate's overall empathetic response. Thus, their studies suggest that neglect, including neglect of mental health issues, exacerbates emotional and behavioral instability issues. The result is more often than not a deficiency in the ability to empathize, use good judgment and learn from experience and consequences. These researchers found that cognitive impairments are widespread and may directly interfere with the ability to respond to or engage in treatment. They also reported that cortisol response to stress, a measure of emotional regulation, was abnormal in inmates who did not respond favorably to treatment. Conventional treatments offered in prisons and jails are not well attended, provided to only a minority of the population, and are unable to remediate the mental and cognitive deficits often presented by inmates. Mental health interventions have the most value and are of the most benefit when they are initiated as early as possible and attention is given to underlying deficiencies.

Many of the inmates studied presented with impulse control disorders which preclude effective decision making and emotional regulation. This, in turn, precludes a favorable treatment response given the conventional approaches offered by prisons. Such inmates are more likely to make disadvantageous decisions; they are unable to consider all the possible outcomes of their actions compared to those who do

not suffer from impulse control disorders. This ability is physiologically-based and significantly influenced by a history of stress exposure. Stress interferes with the development and function of neural networks that are responsible for self regulatory behaviors and emotional states. In addition to cognitive deficits that result from this damage, cortisol release and other aspects of the emotional regulatory system may become impaired. These problems are encountered more often in inmates than in our society's general population given the extent to which they suffer from stress-related disorders (due to poverty, dysfunctional home environments, child maltreatment, head injury, etc.). In the absence of treatment, these impairments will worsen and are likely to manifest as conduct disorders.

These researchers concluded that inmates can be taught how to slow things down mentally so as to make better decisions, and that this can become a learned behavior. Even more importantly, there is evidence that these neural systems can be at least partially remediated with appropriate and effective treatment. Therefore, there is an opportunity for rehabilitation when the correctional environment is managed clinically. These cognitive and behavioral modification programs don't require much effort, but they do require that particular issues presented by inmates be addressed properly. In other words, although it might not be feasible to customize treatment for each inmate, it is possible to identify subgroups of inmates with similar problems who will

likely respond to particular approaches better than others. Thus, there is an opportunity for rehabilitation where traditional correctional punishments, meted out after the offending behavior has occurred, fail. However the rate of improvement becomes increasingly lower for subjects' that are forced to inhabit environments that are not conducive to improving their level of emotional and behavioral regulation. Allowing such deterioration to go uncorrected completely interferes with any desired rehabilitation process.

The researchers concluded that the deterioration of an inmates' mental health is directly associated with negative experiences, emotional neglect and mental mistreatment because these experiences alter cognitive functioning and cortisol responses to stress. This damage is both psychological and physiological. It is long lasting and can be permanent, especially under suboptimal conditions, if not attended to. Thus, this is a key area in correctional operations where the circle of cruelty and hate needs to be broken. This is not a *DeShaney* issue, either, because Standards of Care are Standards of Care.

Thus it can be seen that failing to provide proper mental health treatment to inmates who need it has serious consequences for society at large. It also has some very important constitutional ramifications that need to be resolved and corrected, but in reality *Tony Goodman ex Rel U.S. v. Georgia* and *Jett v. Penner* have already done that. Still, the *Equal Protection Clause* needs to be upheld. Like their

counterparts in mental hospitals, inmates with mental health problems need to receive proper, standardized treatment when they are in jail or in the custody of the state.

When I was an inmate, I did not receive mental health treatment that complied with the state's existing procedures that met existing standards of care, and it was done knowingly. That is my constitutional complaint. The scientific study by *Fishbein et al.* shows that there are serious liabilities to the inmate population, and consequently to the public at large, when treatment environments are not regulated and maintained properly. However, they go further than that by recommending emphatically that inmate behavior modification and control in our nation's correctional facilities needs to be managed clinically. This will go a long way to preventing further psychological and physiological damage to the inmate population's mental health. It would provide a positive treatment environment instead of a negative treatment environment, and it would create the opportunity to reduce the overall liability from crime in our society by taking advantage of the higher level of rehabilitation that cognitive behavioral treatment procedures provide. It is a moot point to consider whether or not the DOJ has formally adopted the recommendations from the *Fishbein et al.* study because the DOJ makes the *Fishbein et al.* study available for downloading to the public on their website, and the DOJ offers no competing studies that advocate continuing traditional correctional methods.

Appendix 6

The bottomline is that complying with the state's regulated standards of care for mental health treatment is a prerequisite for any DOJ sponsored cognitive behavioral treatment program to work.

Since 2006, the knowledge base concerning neuropsychological functioning in inmates' treatment response has been advanced by additional studies. Current information on this subject is reflected by a Jan. 2009 article entitled, *"Deficits in Behavioral Inhibition Predict Treatment Engagement in Prison Inmates."*[2] The additional studies reported in this article serve to provide additional validation to the conclusions that *Fishbein et al.* made in 2006.

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[2] Diana Fishbein, Monica Sheppard, Christopher Hyde, Robert Hubal, David Newlin, Ralph Serin, George Chrousos, Salvatore Alesci, "Deficits in Behavioral Inhibition Predict Treatment Engagement in Prison Inmates," Law Human Behavior DOI 10.1007/s10979-008-9163-7, American Psychology-Law Society-Division 41 of the American Psychological Association, Copyright 2009.

My Point of Contact for this study is Diana Fishbein, the co-author of the DOJ's previous study from 2006:

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Appendix 7

The updated article on, "*Deficits in Behavioral Inhibition Predict Treatment Engagement in Prison Inmates,*" is as follows:

Law Hum Behav
DOI 10.1007/s10979-008-9163-7

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Deficits in Behavioral Inhibition Predict Treatment Engagement in Prison Inmates[3]

Diana Fishbein · Monica Sheppard · Christopher Hyde · Robert Hubal · David Newlin · Ralph Serin · George Chrousos · Salvatore Alesci[4]

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Appendix 8

Abstract: Many inmates do not respond favorably to standard treatments routinely offered in prison. Executive cognitive functioning and emotional regulation may play a key role in treatment responsivity. During intake into treatment, inmates (N = 224) were evaluated for executive functioning, emotional perception, stress reactivity (salivary cortisol), IQ, psychological and behavioral traits, prior drug use, child and family background, and criminal histories and institutional behavior. Outcome measures included program completion, treatment readiness, responsivity and gain, and the Novaco Reaction to Provocation Questionnaire. Relative deficits in behavioral inhibition significantly predicted treatment outcomes, more so than background, psychological, or behavioral variables, and other neurocognitive and emotional regulatory measures. Future replications of these results have potential to improve assessment and treatment of offenders who are otherwise intractable.

Identification of underlying mechanisms in differential responses to treatment for dysregulated behaviors is critical for more effective tailoring of intervention approaches to specific needs of distinctive inmate subgroups (Andrews & Bonta, 2006). Although resources are too scarce to fully match treatments to individuals, at a minimum, the ability to identify characteristics and conditions that compromise treatment responsivity is necessary for

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the development of interventions that more intensively and effectively target existing deficits. A first step toward a better understanding of mechanisms underlying correctional treatment effects is the elucidation of factors that predict the ability of inmates to engage, persist, and show attitudinal and behavioral improvement in response to existing programs.

Evidence is mounting to suggest that integrity of particular executive cognitive functions (e.g., disinhibition, risky decision making, inattention) and emotional regulation (e.g., facial recognition, emotional responses to threat stimuli, psychophysiological stress responses) may represent neural processes underlying variability in responses to treatment programming for behavioral disorders (e.g., Fishbein et al., 2006; Nixon, Paul, & Phillips, 1998). A few existing studies have identified deficits in these functions that, for example, specifically predict response to treatment for drug abuse (Aharonovich, Nunes, & Hasin, 2003; Bauer, 2001; Forman et al., 2004). Findings provide potentially important clues in the search for conditions that may interfere with intervention efficacy for types of psychopathology that involve high risk behaviors. Intact executive functions and emotional regulation may, in fact, be a prerequisite for processing and executing curriculum materials from any treatment program that invokes higher order cognitive abilities, such as cognitive-behavioral therapies, which are commonly employed in correctional settings. Participants with these skill deficiencies may not be as likely to benefit from programs that do not first

address them. Because executive function impairments are malleable (Hermann & Parente, 1996; Manchester, Hodgkinson, & Casey, 1997; Riggs, Greenberg, Kusche, & Pentz, 2006; Rothwell, La Vigna, & Willis, 1999), there is potential for affected individuals to respond favorably to treatment approaches that are specifically targeted to existing deficits (Fals-Stewart, 1993; Grohman & Fals-Stewart, 2004).

Neurocognitive and Emotional Dysfunction and Dysregulated Behavior

Impairments in regulation of executive functions and emotional stress responses have been implicated in the development of dysregulated behaviors such as conduct disorder, heightened aggression, rule-breaking, and drug abuse (Deckel, Hesselbrock, & Bauer, 1995; Fishbein, 2000; Giancola, Martin, Tarter, Pelham, & Moss, 1996; Giancola, Mezzich, & Tarter, 1998; Moffitt, Lyman, & Silva, 1994; Seguin, Pihl, Harden, & Tremblay, 1995; Tarter, Mezzich, Hsieh, & Parks, 1995). Aspects of executive functioning that are relevant to an understanding of dysregulated behaviors include behavioral disinhibition, poor decision-making ability, relative insensitivity to negative outcomes, cognitive inflexibility, impaired problem solving and planning, and emotion misattributions (Mirsky & Siegel, 1994). Aberrant physiological responses to stress (e.g., cortisol release) are also implicated given that their regulation is integral to the establishment and integrity of executive function components

(Raine, Lencz, Bihrle, La-Casse, & Colletti, 2000); a neural network supports a feedback loop in which cognitive demands modify stress responses that, in turn, modify cognitive processing and resultant behaviors (Elliott, Friston, & Dolan, 2000; Liberzon et al., 2000; Steinberg, 2005). Dysfunction of these cognitive and affective domains potentially explains the impulsivity, emotional instability, unresponsiveness to threats of punishment, rules and laws, and negative consequences, as well as an excessive need for stimulation and reward often observed in offender and inmate populations (Dawes et al., 2000; Raine, 1993; Reiss, Miczek, & Roth, 1994; Rogers & Robbins, 2001). The possibility that these behavioral tendencies may further interfere with the ability to respond to treatment makes conceptual sense. Brain systems that support development and function of these neurocognitive and emotional regulatory functions are profoundly influenced by experiences of severe and/or chronic stress (Beers & De Bellis, 2002; Bremner, 1999; De Bellis, Keshavan, Spencer, & Hall, 2000; Steckler & Holsboer, 1999). The pattern and efficacy of an individual's responses to stress have been related to the propensity for high risk behaviors (De Bellis, 2002; Giaconia et al., 2000; Kreek, Schlussman, Bart, Laforge, & Butelman, 2004; Nemeroff, 2004). Thus, it is relevant that offender populations have a particularly high prevalence of adversity relative to the general population (Fishbein, 2000; Martell, 1992; Volavka, Martell, & Convit, 1992) and that aberrant stress responses (e.g., low cortisol responsivity) often characterize aggression,

psychopathy, and impulsivity (Moss, Vanyukov, Yao, & Kirillova, 1999; Oosterlaan, Geurts, Knol,&Sergeant, 2005; Taylor, Carlson, Iacono, Lykken,& McGue, 1999). Such deficits are considered to reflect an underarousal of emotional systems that regulate abilities to process, interpret, and react to social cues (Walker et al., 1991), potentially impeding the ability to respond favorably to interventions that do not address such impairments.

Neurocognitive and Emotional Dysfunction and Treatment Engagement

Damage to structures that constitute the neural circuitry for cognitive-emotive processes (e.g., by stress or adversity [Davidson, 1994; De Haan, Luciana, Malone, Matheny, & Richards, 1994]), can impair regulatory operations during aversive conditioning, reward-related feedback, and riskrelated decision making (see Critchley, Elliot, Mathias, & Dolan, 2000). Theoretically and to some extent empirically, these functional impairments interfere with abilities to integrate new information provided by standard treatment programs and execute the necessary behavioral changes via shifting behavioral strategies based on new information, and/or inhibiting affective responses that promote maladaptive behaviors. This scenario may be especially true for Cognitive Behavioral Therapy-based treatment approaches which form the basis for many standard correctional treatments and reflect Evidence-Based Practice (Serin, 2005). Processing of curriculum materials from Cognitive

Behavior Therapy relies on the ability of participants to (a) be cognizant of and responsive to potential negative consequences of their behavior, (b) inhibit inappropriate behavioral responses, and (c) understand and act on the benefits of deliberate and cautious decision making (Blume, Davis, & Schmaling, 1999; Blume, Marlatt, & Schmaling, 2000). Although Cognitive Behavioral Therapy is generally considered to be the most effective approach available to reducing behavioral problems in this population (e.g., Holbrook, 1997; Nicholaichuk, Gordon, Gu, & Wong, 2000), there is considerable variation in treatment response; a significant subgroup does not respond favorably as indicated by high recidivism and relapse rates, as well as poor attendance, compliance, and retention. Preliminary studies suggest that poor neurocognitive and emotional regulatory function may at least partially explain this variability.

The Current Study

Additional studies are needed to identify neurocognitive and emotional regulatory characteristics that may predict or underlie treatment engagement in prison inmates other than basic background factors which are usually not malleable. To fill this important gap, this study sought to determine whether deficits in executive functions and emotion perception and regulation compromised the ability of inmates to engage, persist, and show attitudinal and behavioral improvement in response to a standard Cognitive

Behavior Therapy-based correctional therapy. We hypothesized that poor treatment engagement, responsivity, and completion, and related behaviors (e.g., aggression) would be predicted by relative deficits in the ability to effectively process and apply curriculum materials reflected by aberrant processing of neurocognitive and affective stimuli, and attenuated cortisol responses at baseline.

METHOD

Participants

Three medium/maximum custodial level facilities in the State of Maryland's Department of Public Safety and Correctional Services (DPSCS) were selected to participate in this study on the basis of programmatic similarities to ensure continuity and uniformity of treatment duration, type and modality of the program, treatment providers, and other environmental factors. A total of 224 male inmates were recruited over a 2.5-year period from a pool who volunteered for the treatment "Thinking for a Change," as part of the "treatment-as-usual" (TAU) procedure in the state prisons. This protocol was approved by both the RTI Institutional Review Board and the State of Maryland. There was no comparison group given the primary hypothesis that variability in engagement relative to a standard treatment approach would be predicted by neurocognitive and emotional regulatory functioning. Inmates who volunteered were first asked to complete an IQ test (Multidimensional Aptitude

Battery); 27 inmates with an IQ below 75 were excluded. Inmates with records indicating that they had mental retardation, dementia, amnesia, and delirium or who were illiterate were not referred to the study investigators by the facilities due to their inability to understand consent and interference by these conditions on their performance. Inmates who met eligibility criteria for study participation were recruited through identification numbers provided by the facility to include only those between 21 and 49 years old with a minimum of 18 months remaining on their sentence to avoid the stress of pre-release preparations and potential transfers. Participants reflected the ethnic diversity of the offender population in the state system. Those eligible were scheduled for testing and signed the full consent form.

Treatment Program Participation

After baseline assessments, inmates began their participation in the facilities' Cognitive Behavioral Therapy-based program. Cognitive Behavioral Therapy is the most widespread treatment approach used in U.S. correctional institutions to reduce violence, drug abuse, sexual offending, and other behavioral disorders common in inmates (Holbrook, 1997; Nicholaichuk et al., 2000). Cognitive Behavioral Therapy is designed to help inmates develop impulse control, manage anger, and learn new behavioral responses to real-life situations. The underlying assumption is that learning processes play an important role in the

development and continuation of antisocial behavior and can be used to help individuals enhance their ability to exert self-control. Cognitive Behavioral Therapy is designed to help patients recognize situations in which they are likely to become agitated or aggressive, avoid these situations when appropriate, and cope more effectively with a range of problems and behaviors associated with aggression.

In the three participating facilities, the DPSCS offers a series of three treatment phases that meet for 90 min twice a week, totaling 50 sessions. The first phase, consisting of 20 sessions delivered by social workers, is called "entry point" and involves curricula on "Thinking, Deciding, Changing." Entry point blends a decision making and cognitive restructuring modality (a self-reflective process to search for triggers of misconduct) into a cognitivebehavioral modality (an external, skill-building process) for self change. Although participation is voluntary, the focus is on inmates who are considered "high risk", including those with multiple incarcerations, history of violence, poor institutional adjustment, and impulsive behavior. The present study focused on performance and retention during this first session only given routinely high drop-out rates. The sole system requirements for retention in the program are that inmates do nothing to undermine the group process and remain free of serious infractions. Immediately after inmates completed the first phase, treatment performance was evaluated by staff on the inmate using treatment readiness and gain and responsivity

scales, program completion, and aggressive reactions to provocation.

Procedures

Consenting inmates underwent baseline testing for several complementary dimensions of neurocognition and emotional regulation and conditions that putatively influence their development. Background and psychological instruments were used to characterize inmates with respect to clinically relevant traits (e.g., drug abuse, impulsivity, aggression, and psychopathy). As measures of engagement and responsivity, social workers provided evaluations and inmates provided self reports. Background, psychological, and neurocognitive and emotional regulation measures were assembled into an assessment battery to determine which variable set best predicted treatment engagement indicators.

Measures

General Intellectual Functioning

The Multidimensional Aptitude Battery (MAB; Sigma Assessment Systems, 1999) was self-administered to identify general intellectual deficits that may have resulted from head injury or other causes and to isolate the predictive value of executive functioning to treatment engagement assuming the hierarchical nature of complex functions (Zelazo, Carter, Reznick, & Frye, 1997). When these more

basic functions are impaired, integrity of executive functions can be expected to suffer as well. Test–retest reliabilities on separately timed test administrations obtained values for total scores of .95 for Verbal, .96 for Performance, and .97 for the Full Scale.

Behavioral and Psychological Questionnaires

A condensed version of the widely used Addiction Severity Index (ASI) (McLellan et al., 1992) was used to assess nature and extent of prior drug use, background factors such as socioeconomic status (Hollingshead rating), religious preference, race/ethnicity, family history of drug use, alcoholism, and mental illness, head injuries, child abuse, medical and psychological status, and other demographic factors. The Self Report Psychopathy Checklist (Hare, 1991; Hart, Lahey, Loeber, Applegate, & Frick, 1995; Levenson, Kiehl, & Fitzpatrick, 1995) is a self-report version of the Psychopathy Checklist-Revised (PCL-R) showing high correlation with the original test and good reliability (Hart et al., 1995). This instrument generates a Primary (e.g., tendency to lie, manipulativeness, and lack of remorse) and Secondary (e.g., impulsivity, quick-temperedness, and lack of long-term goals) psychopathy score. Also, the Reactive-Proactive Aggression Questionnaire (Raine et al., 2006) provided an assessment of predatory (proactive) and impulsive (reactive) aggressive inmates. Confirmatory factor analyses indicated that the two-factor structure produced a

very good fit and item-total correlations ranged from .41 to .57 for the proactive scale, .45–.58 for the reactive scale, and .41–.60 for the total scale. All the three scales have internal reliabilities in excess of 0.83 (see Raine et al., 2006). The Early Trauma Inventory, shown to have acceptable validity and internal consistency (Bremner, Bolus, & Mayer, 2007; Bremner, Vermetten, & Mazure, 2000), was also used as a global indicator of incidences of trauma, witnessing violence, and child abuse and neglect, as well as a subscale measuring symptoms of PTSD.

Executive Cognitive Function Tasks

Knowledge regarding the functional neuroanatomy of cognitive task performance has potential implications for understanding the pathophysiology of behavioral dysregulation and provides a mechanistic account of how interventions mediate their effects (Bremner, 2003; Charney & Deutch, 1996). Thus, the tasks selected for this study have been neuroimaged (either PET or fMRI) to provide information on what areas of the brain are recruited during performance. Importantly, only dimensions of executive functioning that have been associated with behavioral dysregulation and that are conceptually related to treatment responsivity were used; additional tasks would have been informative, however there were severe time constraints for testing given the prison environment. Neurocognitive and emotional perception tasks were computerized and nonintrusive. Inmates were tested individually

at a time that did not interfere with meals, lock-downs, or counts. Questionnaires and neurocognitive tasks (see Table 1) were administered in the mornings (tasks were administered first to avoid the effects of fatigue on cognitive functioning) and the stress task was conducted in the afternoon.

The Cambridge Decision Making Task (CDMT: Rogers et al., 1999a, 1999b) was developed to dissect the cognitive components involved in decision making and measures willingness to take risks and relative sensitivity to rewards versus penalties. It has been found to have sensitivity and specificity in high-risk populations (see Fishbein et al., 2005b for a complete description) and reliably activates a portion of the PFC and the anterior cingulate involved in social skills, impulse control, and sensitivity to rewards (Fishbein et al., 2005a). In this task, larger rewards are always associated with the least likely outcome, thus capturing the conflict inherent in risk-taking situations. A tendency to take more risks in all conditions in pursuit of a large reward and with a willingness to tolerate an even higher probability of a large loss was expected to predict a lack of positive behavioral change in response to the experimental intervention. Performance measures generated by this task included in our model were percentage of the riskiest decisions and mean reaction time for riskiest decision. Two outliers were discovered for mean reaction time on this task (skewness = 3.5). With their removal, skewness was significantly reduced (skewness = 1.1) and the distribution became more normalized; thus, analyses including this variable excluded these two subjects.

Appendix 21

Table 1: Test battery

	Measurement instruments.
Predictor variables	
Executive cognitive performance	Cambridge Decision Making Task, Logan Stop-Change Task, Stroop Color-Word Interference Task
Emotion perception Emotional regulation	Facial Recognition Task Speech Task with Cortisol Sampling SCL-90
Potential moderator variables	
General intellectual functioning	Multidimensional Aptitude Battery
Demographics, drug and alcohol use, family history, etc.	Background Inventory (adapted from the ASI)
Psychopathy traits	Self Report Psychopathy Checklist
Aggression type	The Reactive-Proactive Questionnaire
Past failures/successes	Success Inventory
Events that could alter treatment response	Events Checklist
Lifetime stress exposures	Early Trauma Inventory
Outcome variables	
Change in behavioral control	Novaco: Reactions to Provocation
Institutional behaviors	OBSCIS Data on Good

Appendix 22

	Conduct Points
Treatment response/ progress	Responsivity and Gain Scales from Social Workers
Treatment completion	Completion of first session

SCL-90 Symptom Checklist-90,
ASI Addiction Severity Index,
OBSCIS Offender Based State Correctional Information System

The Stop-Change Task (SCT) measures impulsivity and response shifting (Logan & Burkell, 1986 and see Fishbein et al., 2006 for full description) and has been shown to activate the right hemispheric anterior cingulate cortex, supplementary motor area, and inferior prefrontal and parietal cortices, which modulate error monitoring, interference control, and task management (Rubia et al., 2001). This task requires deep concentration, impulse control, timing, and the ability to shift responses in light of newly presented information (a novel stimulus). Measures from this task include percentage correct and reaction time (RT) for all the trials that included presentation of a new stimulus.

The *Stroop Interference Task* uses previously learned information to assess the three attributes of executive frontal lobe function: complexity, a "nonroutine" nature, and the novel use of old information. Patients with frontal lobe damage are typically influenced by stereotypical thinking, which would interfere with the ability to produce the atypical responses required on the Stroop (Luria,

1980; Mesulam, 1986), and often experience difficulty with mental flexibility (Stuss & Benson, 1986). Studies suggest that the anterior cingulate (believed to be involved in aggression) is primarily recruited for performance on the Stroop (Bench et al., 1993; Pardo, Pardo, Janer, & Raichle, 1990). The primary score generated by the Stroop is the "interference score," calculated by multiplying the first two conditions (W = word score and C = color score) and dividing that product by the sum of those conditions to produce a "CW prime" score (W 9 C/W ? C = CW0). CW0 is then subtracted from the sum of third condition (CW) score (CW - CW0 = interference).

Emotion Perception

Research suggests that emotion-processing deficits lead to a distorted perception of social cues that has been associated with aggressive and disruptive behaviors (Crick & Dodge, 1996; Dodge, 1980). PFC impairment reduces inhibition of emotional behaviors that may be generated from these distorted perceptions; thus, measurement of emotion perception is critical. A Facial Expressions of Emotion: Stimuli and Test (FEEST: Ekman & Friesen, 1975) involving a facial recognition technique was used due to its high level of validity and reliability. Emotion attribution has been directly related to the function of the amygdala (McClure et al., 2004; Whalen et al., 2001; Williams et al., 2004; Yang, Menon, Reid, Gotlib, & Reiss, 2003) and is shown to be impaired in individuals with externalizing disorders, such as ADHD, psychopathy,

and drug abuse (Blair, Colledge, Murray, & Mitchell, 2001; Kornreich et al., 2003; Kossen, Suchy, Mayer, & Libby, 2002). This task requires that subjects identify one of six emotions (happiness, sadness, surprise, fear, disgust, and anger) that best describe the faces (10 for each expression). The scores produced included the number of errors in attributions of each emotional expression and total correct responses.

Emotional Regulation and Stress

The significant effect of public speaking on emotional and physiological stress responses has been well demonstrated (see Rohrmann, Hennig, & Netter, 1999). Inmates were instructed to make a 10-min persuasive speech providing justification to a parole board for an early release which was ostensibly judged by the research assistant according to how compelling and effective it was, and in terms of its formal aspects and content. Salivary cortisol levels, which correlate well with free serum cortisol levels, were measured during the treatment baseline to assess inmates' stress response to emotional stimuli (Yao, Moss, & Kirillova, 1998). The task was administered in the afternoon when cortisol is most stable. Two resting state samples of saliva (2 ml) were collected after an acclimation period and immediately before the speech. Two additional samples were taken 20 min after the speech, representing the peak cortisol response. Cortisol tends to rise about 20 min after a stressor and then falls precipitously, thus we were able to evaluate the

ascending curve to assess the relationship between treatment engagement and extent of effective elevation in cortisol.[5]

In order to evaluate the inmates' present emotional and psychological state which may influence stress responses, the Symptom Checklist-90 (SCL-90) was administered immediately before this task (Derogatis, Rickels, & Rock, 1976). The Global Severity Index from the SCL-90 was used as a covariate in analyses of cortisol data.

Treatment Performance Indicators

Behavioral performance measures, questionnaires, official records, and evaluations from social workers were used (Table 1). Treatment readiness and gain and responsivity were evaluated by Social Workers using an instrument designed to assess Cognitive Behavioral Therapy preparedness and performance (Kennedy & Serin, 1997, 1999; Serin, 1998; Serin, Mailloux, & Kennedy, 2007). Each of these three domains is represented by a description and a 4-point rating scale with behavioral examples for each subscale. A Treatment Readiness clinical rating was adapted for use as a

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[5] The saliva samples were stored at -20oC until processing. They were then centrifuged to remove particulate matter and extracted with hexane: ethyl acetate. Aliquots of the extract were evaporated to dryness in a rotary evaporator. The dried extract was redissolved in buffer and the cortisol content was determined using a highly sensitive RIA procedure with, 125I-radiolabeled cortisol. Sensitivity of the method is 0.05 mg/dl using 0.2 ml of saliva (Esoterix Inc., Austin,

self report measure (see Casey, Day, Howells, & Ward, in press; Day et al., 2008; Serin et al., 2007) and has shown acceptable intraclass correlations (Y. Lee, unpublished data; L. Marshall, unpublished data). Subscales of this rating include: problem identification, macro treatment benefits, micro treatment benefits, treatment distress, treatment goals, treatment behaviors, behavioral congruency, and treatment support. Subscales were combined to produce a total readiness score for this performance domain (Cronbach's a = .73 in the present study, and .83 in Serin et al., 2007). This instrument was administered at baseline, prior to neurocognitive assessments and treatment participation. Although this measure is technically not an outcome measure, it was included in a separate regression model to determine whether neurocognitive, emotional regulation, and background measures predicted the extent to which inmates perceived themselves to be ready for treatment.

Treatment indicators were further evaluated by social workers using a combination of the Treatment Responsivity and Gain Scales immediately after the first treatment phase. The Responsivity subscales reflect personality dimensions putatively related to treatment performance and include Callousness, Denial, Procrastination, Intimidation, Power and Control, Rigidity, Victim Stance and Procriminal Views (Cronbach's a = .85). The Gain subscales reflect program participation and performance, such as Evidence of Increased Skills from Program, Disclosure in Program, Application of Knowledge,

Application of Skills, Depth of Emotional Understanding of Program Content, Appropriateness of Behavior in Group, Participation, and Therapeutic Alliance (Cronbach's a = .90). Items within each scale, in a 4-point Likert scale format (i.e., 0–3), were completed by social workers based on their observations of inmates participating in their treatment groups and in the research protocol. Social workers were instructed to consider change in behavior, skills, attitude from commencement to present evaluation in their responses. Descriptions were provided of each subscale; e.g., Evidence of Increased Skills From Program subscale: "This item considers the development of specific skills the treatment program is intended to impart. A higher score indicates the inmate has exhibited the increased ability to do more than simply repeat in group that which has been demonstrated in previous group sessions."

The Novaco Reaction to Provocation inventory (Novaco, 1994) was given at baseline and again after completion of each treatment phase. There are two parts, the first set of subscales assessing cognitive, arousal, and behavioral domains and the second assessing impulsive reaction, verbal aggression, physical confrontation, and indirect expression. This instrument is sensitive to behavioral change particularly in response to an intervention. Noncompletion of the program due to disinterest, commission of an infraction and/or time in segregation, disruption to the group, lack of cooperation, or a related 'negative' reason was considered a poor treatment outcome.

Noncompletion due to a 'neutral' cause such as obtaining a job, mandatory transfer, or other reason unrelated to noncompliance was excluded in analyses; their reasons for noncompletion were considered "neutral" and not indicative of a good or bad outcome. Inmates who dropped out of treatment were retained in the study and in all possible cases were tested according to the same schedule as those who remained in treatment. Also, only those who remained in treatment for at least two weeks were included in the analyses; treatment engagement and responsivity cannot be measured in inmates who discontinued early as exposure would be insufficient to obtain self evaluations and social workers would not have sufficient familiarity with the inmates to provide an evaluation.

Results

Statistical Techniques

Primary analyses were restricted to performance during and immediately after the first treatment phase due to the large numbers who did not progress beyond that stage in treatment (see Table 2). Extraordinarily high attrition rates are common in prison treatment programs (Hiller, Knight, & Simpson, 1999); thus, one focus of this study was to determine whether neurocognitive and emotional regulation factors predicted attrition. Also note that sample sizes differ for various analyses given missing data. In all the analyses, $p<0.05$ was considered significant.

Appendix 29

A score (t2 - t1) reflecting change from baseline to the time period after the first treatment phase (whether or not participants completed) was calculated for the total score on the Reaction to Provocation measure as another outcome potentially related to treatment participation. A linear regression analysis was conducted with change scores as the dependent variable and background and cognitive measures as predictor variables.

Two salivary cortisol samples were obtained prior and subsequent to stress task administration during the treatment baseline; each subset of two samples was averaged to generate a baseline and posttest value. In cases where only one sample was viable, no averaging was conducted. Standardized values (z-scores) were calculated for baseline and posttest cortisol levels and relative change from baseline was computed by subtracting baseline from posttest z-scores. Analyses including cortisol measures were adjusted for Body Mass Index (BMI) given the inverse

Table 2 Sample descriptives

	N	Min	Max	Mean	StdDev
Age of inmate	224	21	49	31.08	5.76
Verbal IQ	224	70	117	88.04	11.49
Performance IQ	224	70	136	90.46	15.11
Full scale IQ	224	70	122	88.50	12.37

Appendix 30

Months in prison	221	1	251	38.67	40.53
Years of education	224	4	21	11.39	1.69
Weight (lbs)	220	135	360	202.37	36.94
Height (inches)	220	60	83	67.26	3.08
Treatment for alcohol abuse	225	0	20	.77	2.11
Treatment for drug abuse	225	0	24	1.36	3.14
PCL-primary psychopathy	222	12	54	32.29	8.60
PCL-secondary psychopathy	222	9	37	23.17	5.58
Proactive aggression	225	0	24	6.29	4.76
Reactive aggression	225	0	24	11.16	4.58
SCL-GSI	195	34	81	59.99	12.56

PCL Psychopathy CheckList,
SCL-GSI Symptom Checklist-90 Global Severity Index

relationship between abdominal obesity (as measured by BMI) and HPA Axis function (Rosmond, Dallman, & Bjo¨rntorp, 1998). BMI was calculated by dividing weight (kg) by height (meters squared). Also, since correlations between SCL-90 scores and cortisol levels were nonsignificant, cortisol change

scores were used in regression models that only included adjustments for BMI.

A hierarchical multiple regression ("sequential regression" statistical model) was conducted to attempt to delineate which of the neurocognitive and emotional regulation variables best predicted each treatment outcome (dependent variable). This hierarchical approach to multiple regression allows determination of whether the final predictor—the neurocognitive or emotional regulation measure—entered into the regression equation can explain a significant proportion of the variance in the dependent variable over and above that of which is attributable to earlier data sets. It thus represents a conservative test of the effect of the variable(s) of interest in that variables first entered are maximized. For all models, background covariates included age, IQ, and education. Additional covariates were included in the secondary set of predictors based on a significant correlation with either treatment outcomes or neurocognitive and emotional regulation measures; thus, for all models, covariates included the primary psychopathy measure, reactive aggression, the global severity score from the SCL-90, family history of alcoholism, and average amount of previous drug usage. For Treatment Gain and Treatment Responsivity, and Reaction to Provocation outcomes, a history of physical abuse was added. Also for Reaction to Provocation, a history of emotional abuse was added based on their correlation, and the reactive and proactive aggression measures were excluded given their conceptual and empirical overlap with this

outcome. An R2 change, an F change, degrees of freedom (df), and the t statistic are reported to explain how much each individual predictor (i.e., neurocognitive or emotional regulation measure) contributed to the variation in the dependent variable controlling for both the first (background) and second (psychological and behavioral) sets of variables. And covariates that were significantly related to each outcome in the final models are included.

Treatment completion was coded as 0 or 1, reflecting completion or discontinuation of the first phase. Each treatment outcome was modeled as a linear function of each neurocognitive and emotional regulation measure and covariate factors using logistic regression methods. Covariates included in models were those that were significantly related to either neurocognitive/emotional regulation measures or outcomes and were entered in a stepwise fashion. Age, education, and IQ were entered into the model first, and history of physical abuse and psychological problems in the past 30 days were entered second. Omnibus tests were conducted of the net effect of each neurocognitive and emotional regulation variable separately on treatment outcomes after adjustment for covariates. Thus, v2, degrees of freedom, Cox & Snell R2 (which provides a test of strength of the association and not percentage of variance explained in a logistic regression model) are reported for the third block of each model. Also, those covariates that were significantly related to each outcome in each model are shown.

Appendix 33

Preliminary Analyses

Table 2 presents a description of the combined population including inmates from the three prison facilities combined. In total, 17.7% were Caucasian, 73.7% were African American, and 5.6% fell into other ethnic/racial categories. Approximately 44% reported having had depression, 38% anxiety, 44% violent behavior, and 13% had suicide attempts in their lifetimes. Data gleaned from official records (OBSCIS) indicated that 3% committed primarily property offenses, 32% were primarily drug offenders, and 65% had violent offense records. The following percentages reflect a history of psychopathology among immediate family members: alcoholism = 46.4%; drug abuse = 52.2%; and mental illness = 22.8%. A total of 28.3% (n = 71) reported severe head injury ([3 min unconsciousness). A preliminary analysis was conducted to determine whether history of head injury predicted treatment response; those with head injury had less treatment gain ($p<0.05$) than those without head injury. The only neurocognitive or emotional regulatory dimension related to head injury was inhibition/response shifting and for all central neurocognitive and emotional regulation variables, their contributions to treatment gain appeared to be independent; interaction effects between head injury and each neurocognitive and emotional regulation domain on treatment outcomes were insignificant. On the other hand, those with head injuries had more psychological problems in the last 30 days, a greater history of physical, emotional, and sexual

abuse, and higher levels of both proactive and reaction aggression.

Correlation analyses were conducted between predictor variables. Results suggest a relatively low level of multicollinearity: the Stroop Interference Score and cortisol levels ($R = .211$, $p<0.05$), reaction time on the CDMT ($R = -.22$, $p<0.01$), and percentage correct on the SCT ($R = .26$, $p<0.005$). The percentage correct on the SCT was also related to the total score on the FEEST ($R = .19$, $p<0.05$) and the CDMT reaction time ($R = -.16$, $p<0.05$). Reaction time on the SCT and percentage of safe choices on the CDMT were not significantly related to any other independent measure.

Correlations were also computed to assess relationships among treatment outcome variables (with the exception of the dichotomous variable treatment completion). For most measures, outcomes were unrelated to one another, suggesting that they are likely measuring different treatment dimensions (results not shown) and providing justification for including them as separate constructs. Thus, these instruments are likely measuring different treatment outcome dimensions. Due to strong convergence, however, between scores on the Treatment Responsivity and Gain subscales ($R = .965$, $p<0.001$), responses were combined to produce a total responsivity and gain score for these performance domains. Cronbach's a for this combined construct was .92, suggesting high internal validity.

A final preliminary analysis assessed correlations between each treatment outcome and background, behavioral, and psychological variables.

Unexpectedly, very few significant relationships emerged between background, behavioral and psychological characteristics, and treatment outcomes. There were no variables significantly related to Treatment Readiness. Those inmates with greater Treatment Responsivity and Treatment Gain reported less physical abuse: $R = -.17$, $p<0.05$ and $R = -.14$, $p<0.05$, respectively. Reaction to Provocation Change scores were related to history of physical abuse ($R = -.30$, $p<.0001$), history of emotional abuse ($R = -31$, $p<.0001$), proactive aggression ($R = -.35$, $p<0.0001$), and reactive aggression ($R = -.35$, $p<0.0001$). And in an ANOVA analysis, program completers reported a lesser history of physical abuse ($F = 8.89$, $p = 0.003$) and experiencing psychological problems a fewer number of days in the last month ($F = 6.19$, $p = 0.01$). As stated above, background, psychological, and behavioral variables that were significantly related to each outcome or neurocognitive/emotional regulation measure were included as covariates in the models described below; e.g., childhood physical abuse was included as a covariate in models with Reaction to Provocation Scores.

Neurocognitive and Emotional Regulatory Predictors of Treatment Responses/Outcomes

Treatment Readiness

Higher levels of self-reported treatment readiness were associated with fewer correct ($t = -2.64$, $p<0.05$) and shorter reaction times ($t = -2.02$,

$p<0.05$) in response to delay tone trials on the impulsivity task. Also, reaction times in response to risky decisions on the CDMT were shorter in those who perceived greater treatment readiness ($t = -2.58$; $p<0.01$). Change in cortisol during the stress task was more pronounced in those who viewed themselves as more treatment ready relative to those who reported less readiness ($t = 2.03$; $p<0.05$) (see Table 3).

Treatment Gain and Responsivity

Treatment Gain and Responsivity scores were strongly and positively related to percent correct ($t = 4.44$, $p = 0.0001$) and reaction times ($t = 3.59$, $p<0.0001$) on the SCT. RT during risky decision making on the CDMT was also predictive of Responsivity ($t = 1.83$, $p<0.05$) (Table 4).

Treatment Completion

Inmates who completed the first treatment phase, and excluding those who began treatment but dropped out for reasons unrelated to treatment engagement or progress (e.g., transfer, work, etc.), exhibited less impulsivity with a greater percentage of correct responses on the SCT ($v2 = 4.61$, $p<0.05$) and longer RTs ($v2 = 3.43$, $p<0.05$) than noncompleters. They also showed lengthier reaction times in response to risky trials on the CDMT ($F = 14.98$, $p<0.05$) (see Table 5).

Table 3 Hierarchical regression analyses demonstrating contribution of neurocognitive measures to variance in Treatment Readiness

Neurocognitive Measure	R^2 change	F change	N (df)	t
SCT: total % correct	.04	6.96**	166 (1,156)	-2.64
SCT: average RT	.02	4.68*	166 (1,156)	-2.02
CDMT: percent safe trials	.01	0.91	177 (1,167)	.95
CDMT: RT to risky trials	.04	6.64**	175 (1,165)	-2.58
Stroop: interference score	.00	0.04	139 (1,129)	-.20
FEEST: total correct	.01	1.16	177 (1,167)	1.08
Cortisol:. change score	.04	4.12*	107 (1,97)	2.03

The Sig. Covariate for all measurements is not applicable with the exception of 'Cortisol: change score,' which has a sig. covariate noted as 'education.'

SCT Stop Change Task, CDMT Cambridge Decision Making Task, FEEST Facial Expressions of Emotion: Stimuli and Test, RT Reaction Time
* $p<0.05$, ** $p<0.01$

Model 1: IQ, age of inmate, years of education

Model 2: IQ, age of inmate, years of education, PCL-prim, SCL-GSI, reactive aggression, average amount of use of all drugs, family history of alcoholism

Model 3: IQ, age of inmate, years of education, PCL-prim, SCL-GSI, reactive aggression, average amount of use of all drugs, family history of alcoholism, one central measure from each neurocognitive task entered in separate models

Table 4 Hierarchical regression analyses demonstrating contribution of neurocognitive measures to variance in Treatment Gain and Responsivity

Neurocognitive Measure	R^2 change	F change	N (df)	t
SCT: total % correct	.11	19.75**	164 (1,153)	4.44
SCT: average RT	.07	12.91**	164 (1,153)	3.94
CDMT: percent safe trials	.00	0.19	175 (1,164)	-0.43
CDMT: RT to. risky trials	.02	3.33*	173 (1,162)	1.83
Stroop: interference score	.01	2.02	140 (1,129)	1.42
FEEST: total correct	.00	1.01	175 (1,164)	-1.01
Cortisol:. change score	.00	0.23	106 (1,95)	0.48

The Sig. Covariates for each measurement in order are: famhx alc; n/a; phys abuse; famhx alc, phys abuse; reactive agg, famhx alc; famhx alc, phys abuse, age; and, age, psychopathy.

SCT Stop Change Task, CDMT Cambridge Decision Making Task, FEEST Facial Expressions of Emotion: Stimuli and Test, RT Reaction Time * $p<0.05$, ** $p<0.001$

Model 1: IQ, age of inmate, years of education

Model 2: IQ, age of inmate, years of education, history of physical abuse, PCL-prim, SCL-GSI, reactive aggression, average amount of use of all drugs, family history of alcoholism

Model 3: IQ, age of inmate, years of education, history of physical abuse, PCL-prim, SCL-GSI, reactive aggression, average amount of use of all drugs, family history of alcoholism, one central measure from each neurocognitive task entered in separate models.

Change in Reaction to Provocation Score

As seen in Table 6, less improvement in terms of reactions to provocation before and after the first treatment group was associated with fewer safe choices in the CDMT ($t = 2.03$, $p<0.05$).

Appendix 40

DISCUSSION

The most prominent finding from this research was that inmates exhibiting a relative lack of behavioral inhibition and inability to shift responses based on new information were less likely to progress favorably in a standard correctional treatment program, more likely to drop out early, and less likely to report improvement in aggressive reactions to provocation. Indicators of impulsivity included both the inability to respond correctly in the presence of a distracter stimulus and reaction time, which was significantly shorter in poor responders. This behavioral orientation has implications for social competency skills that may influence amenability to treatment and ultimate behavioral outcomes.

Impulsivity has been consistently found to act as an important risk factor in a wide range of high risk behaviors, including aggression and drug abuse (Dawe & Loxton, 2004; de Wit & Richards, 2004). Individuals with impulse dyscontrol disorders have difficulties in generating socially adaptive behaviors and executing skills to avoid aggressive responses or stressful interactions. Also, compromised impulse control over behavior may permit hostility, negative affective states, and other maladaptive responses to dominate behavior (Giancola, 1995). These dimensions of impulsivity may operate to interfere with the ability to engage and persist in treatment programs as well. Additional support for this finding would suggest that behavioral inhibition may be a prerequisite for program participation and retention,

particularly when interventions do not first reinforce the building blocks for effective behavioral inhibition. Thus, impulsivity may play a critical role in treatment responses which rely heavily upon the ability to resist impulses to engage in behavior that has yielded immediate intrinsic rewards (e.g., the control from aggressive behavior or euphoria from illicit drugs) despite longer term negative consequences. Recent data such as those presented in this study suggest the need to match interventions to relevant personality traits such as impulsivity to improve intervention outcomes in general (Moeller et al., 2001; Staiger, Kambouropoulos, & Dawe, 2007).

Table 5 Logistic regression model showing group differences between drop out and completion groups

Neurocognitive measure	Drop-outs N	Completers N	χ^2	Cox & Snell R^2
SCT: total % correct	57	81	4.61*	0.10
SCT: average RT	57	81	3.43*	0.09
CDMT: % safe trials	65	85	0.31	0.08
CDMT: RT to risky trials	65	83	14.98*	0.10
Stroop: interference score	44	73	0.88	0.08
FEEST: total correct	66	85	1.12	0.10
Cortisol change score	33	58	1.37	0.06

The Sig. Covariates for each measurement in order are: psyc problems x2; psyc problems, phys ab x3; phys ab; and, n/a.

SCT Stop Change Task, CDMT Cambridge Decision Making Task, FEEST Facial Expressions of Emotion: Stimuli and Test, RT Reaction Time * $p<0.05$

Statistics represent a test of the predictive power of the cognitive variable entered into the third block, after adjusting for block 1 (IQ, age, education) and block 2 (history of physical abuse, psychological problems in last 30 days)

Table 6 Hierarchical regression analyses demonstrating contribution of neurocognitive measures to variance in Change in Reaction to Provocation

Neurocognitive Measure	R^2 change	F change	N (df)	t
SCT: total % correct	.011	1.51	123 (1,112)	-1.23
SCT: average RT	.00	0.01	123 (1,112)	0.02
CDMT: percent safe trials	.028	4.11*	127 (1,116)	2.03
CDMT: RT to. risky trials	.02	2.67	125 (1,114)	1.63
Stroop: interference score	.00	0.21	105 (1,94)	-.46

FEEST: total correct	.001	0.077	127 (1,116)	0.28
Cortisol:. change score	.01	1.12	84 (1,73)	-1.06

The Sig. Covariates for each measurement in order are: hx emo abuse x2; hx emo abuse, hx phys abuse; hx emo abuse x4.

SCT Stop Change Task, CDMT Cambridge Decision Making Task, FEEST Facial Expressions of Emotion: Stimuli and Test, RT Reaction Time * $p<0.05$

Model 1: IQ, age of inmate, years of education

Model 2: IQ, age of inmate, years of education, history of physical abuse, history of emotional abuse, PCL-prim, SCL-GSI, average amount of use of all drugs, family history of alcoholism

Model 3: IQ, age of inmate, years of education, history of physical abuse, history of emotional abuse, PCL-prim, SCL-GSI, average amount of use of all drugs, family history of alcoholism, one central measure from each neurocognitive task entered in separate models

Impulsive responding on neurocognitive tasks similar to that used in this study has been consistently shown to recruit the brain's prefrontal cortex (PFC) and its neural circuitry (King, Tenney, Rossi, Colamussi, & Burdick, 2003; Martin & Potts,

2004; Watanabe et al., 2001) which regulates planning skills, sensitivity to consequences, impulse control, and other complex social behaviors. Development of the brain circuitry underlying impulse control is in transition throughout adolescence and into early adulthood; the PFC and its connections remain underdeveloped relative to other brain regions until about age 25 (Giedd, 2004). As a result, impulsive behaviors are developmentally expected in adolescence. Enhancing risk for developmental delays that may lead to enduring impulsive behavior is the heightened sensitivity to severe psychosocial and physical stressors (e.g., head injury, drug or alcohol use, deprivation, child abuse) during this critical developmental period (Chambers, Taylor, & Potenza, 2003). Evidence for this possibility is seen in adults with a history of trauma who exhibit high levels of impulsivity and other risk taking behaviors; several studies have reported PFC developmental delays or deficits in this population (e.g., Berlin, Rolls, & Iversen, 2005; Rodriguez-Jimenez et al., 2006; Spinella, 2004). Perhaps not coincidentally, therefore, physical and psychological trauma which can compromise PFC development and latter functioning is more prevalent in criminal offenders than in the general population (Blake, Pincus, & Buckner, 1995; Neller, Denney, Pietz, & Thomlinson, 2006). These findings provide one potential explanation for their high rates of impulsivity and, possibly for inmates' particular intractability to treatment.

Interventions may be more beneficial to the inmate population if they first address the level of

proficiency of an inmate's behavioral inhibition skills and their use of techniques for weighing consequences. Training in the prediction of outcomes and development of a future orientation among other related skills may, then, reinforce the ability to withhold impulsive responses and act on an assessment of consequences (Trad, 1993). Treatment program strategies to help inmates "slow down and think" and control impulsive reactions may be indicated given that the subgroup most likely to be unresponsive to treatment may be impulsive, resulting in a counterproductive decisions. Cognitive rehabilitation approaches may be particularly effective in addressing efficiency of behavioral responding. Remediation targets learning, attention, problem-solving, and visual-spatial skills using two approaches: repeated exposure to a task and/or the deconstruction of complex tasks into their simpler component parts. For example, components of a complex task such as scanning or psychomotor speed are trained separately and then integrated into performance on the complex target task. The training also focuses on memory and problem-solving, stressing the use of strategies such as forming images or drawing diagrams.

Another significant finding in this study is that stress reactivity, as measured by cortisol levels, predicted treatment readiness, consistent with van de Wiel, van Goozen, Matthys, Snoek, and van Engeland (2004) and Zimmermann, Blomeyer, Laucht, and Mann (2007); lower cortisol reactivity was associated with self evaluations of lower

readiness. Abnormally high levels of cortisol release are related to acute stress and anxiety, however, relative cortisol insensitivity may be reflective of either a genetic propensity to lower stress reactivity or a dampening of stress responses that can occur after chronic exposure to stressful situations. It is also possible that a stress response or some level of negative affect is required to engage in treatment (McKay, Alterman, & Mulvaney, 1999). This study cannot determine the origins of low stress responses in those who performed less well in treatment. However, given that chronic or severe stressful experiences are known to (a) produce cognitive impairment and stress response dampening, (b) dysregulate emotional responses, (c) increase the likelihood of recidivism and relapse, and (d) interfere with treatment benefits, approaches to minimize the impact of stress may eventually prove to be a critical component of treatment for affected inmates. Cortisol dysregulation as one index of physiological stress reactivity has been found to be malleable in response to interventions. For example, Fisher, Gunnar, Chamberlain, and Reid (2000) and other investigators provide evidence for the impact of a targeted intervention on cortisol (Bruce, Kroupina, Parker, & Gunnar, 2006; Gunnar, Morison, Chisholm, & Schuder, 2001; Hammerfald et al., 2006; Mommersteeg, Keijsers, Heijnen, Verbreaak, & van Doornen, 2006). There are also potential implications for altering autonomic reactivity in general with appropriate interventions (e.g., McCraty, Atkinson, Tomasino, Goelitz, & Mayrovitz, 1999; Raine, 1996), suggesting a possible mediating

role for stress responsivity. Nevertheless, the relationship between stress and perceived treatment readiness is still a poorly understood phenomenon.

Other Related Findings

IQ did not relate to treatment outcomes and most of the models remained significant with its inclusion, suggesting that higher order cognitive functions, and not subservient cognitive functions, played a more direct role in treatment engagement outcomes. Also, younger inmates fared better in treatment, but total months in prison were not predictive of outcomes. This finding may be interpreted to suggest that younger inmates may be more tractable irrespective of how long they have been in prison. Additional background variables were similarly unrelated directly to treatment outcomes, including education, duration of total prison time, family history of criminality and mental illness, drug abuse history, and psychopathy. On the other hand, there was a general pattern for physical abuse and psychological problems in the last 30 days to contribute independently to poor treatment response. In light of the extant research on this subject, it is critical that treatment providers consider childhood trauma and its related psychological manifestations as possible concomitant conditions that can potentially disengage inmates from treatment and result in diminished amenability to program demands. Nevertheless, when these factors were included in models with neurocognitive and

emotional regulation measures, they did not retain their significance. And importantly, although various measures from each of the neurocognitive and emotional regulation tasks significantly predicted particular treatment outcomes and low cortisol responses also predicted treatment completion (data not shown), these factors also did not retain their significance with the inclusion of relevant covariates in the models. These results suggest the potentially influential role of disinhibition in treatment engagement over and above other inmate characteristics.

Interestingly, self evaluations of treatment readiness differed from social worker evaluations and were not predictive of actual treatment performance indicators. We speculate that those inmates who have an inflated sense of how well they may fare in treatment may be at particular risk for negative outcomes. It may also be relevant that a robust cortisol response to a stressor typified those who evaluated themselves as being highly treatment ready. Based strictly on years of observations of prisoners, this finding may suggest that inmates who report being treatment ready and who have lowered stress responsivity may be less able to predict their performance in treatment, and less enthusiastic and compliant. Inmates with a higher cortisol response and who report less treatment readiness may simply be more committed to change and anxious about their ability to perform well; i.e., they may have a higher level of responsivity to social stimulation. The implications of this finding for treatment will be explored in future research.

FINAL REMARKS

There are several limitations in this study. High levels of noncompletion in prison treatment programs make it difficult to assess the 'effects' of treatment on cognitive functioning or any other measure. On the other hand, this study intended to predict individual differences in level of engagement, persistence, and improvement in a correctional treatment program, which may be more reflective of the inmates' baseline willingness and ability to respond favorably and not the effects of any given treatment approach. Similarly, the lack of a placebo control group limits conclusions to some extent; however, the purpose of this study was to compare inmates with varying levels of participation rather than evaluate the treatment program. Another shortcoming is that there is no method by which we could assess selection bias. Inmates were referred to the study team based on preexisting criteria, thus, a comparison of inmates referred with those who were not referred was not possible. The response rate was exceedingly high, however, in that all of those recruited and considered eligible participated in the research. Also, use of self reports to evaluate behaviors, including nature and extent of drug use, and psychological traits is not ideal without corroboration or more extensive testing. Primary measures, however, were performance tasks and not prone to errors due to recall, selective memory, bias, and other common issues in surveys.

In short, our findings tentatively suggest that behavioral disinhibition may be informative in identifying treatment readiness preparations that are necessary for inmates to be able to respond to existing intervention strategies. Replications of these preliminary findings would indicate that new approaches to correctional treatment may include a cognitive neurorehabilitation component designed to enhance connectivity between neural systems and strengthen these malleable cognitive and emotional regulatory functions to more effectively modify behavior in inmates. Incorporation of this knowledge into criminal justice policies and practices may eventually alter their course substantially, dramatically improving agencies' ability to assess, detect, and treat offenders who are currently considered intractable. (Note that if this represented only 10% of inmates in custody in the US, based on Bureau of Justice Statistics December 2005 statistics, this would affect about 219,000 individuals).

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